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VOLUME 12

THE CHILD

JULY 1947

to JUNE 1948

FEDERAL SECURITY AGENCY Social Security Administration • Children's Bureau

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MEDICAL-SOCIAL WORKER HELPS BLIND BABIES TO GET GOOD START

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JUL 25 1947

RUTH M. BUTLER,

Medical-Social Worker, Massachusetts Eye and Ear Infirmary, Boston

IF A BLIND CHILD is to grow up to be an acceptable member of his family, of his neighborhood, and of his community, he needs mother love and a secure place in his home even more than other children do. And a first step in helping a blind baby toward a happy and useful future is to help to relieve emotional or other strains on his mother.

This may mean that the medical-social worker in a program for meeting the needs of blind children is at one time arranging hospitalization; at another, raising funds for housekeeping service when the mother is unable to attend to her home duties; or trying to place the blind child in a foster-family home; or seeking a nursery school that will accept him.

But basically it means that the worker, in trying to relieve family strains, is not only providing services for the child but is helping to strengthen the tie between the mother and the child, which may be weakened even to the breaking point by his blindness.

After a doctor diagnoses blindness in one of our baby patients, almost always the mother needs help in facing the facts and in seeing them in perspective. We try to give her this help, for unless she is able to acknowledge, both intellectually and emotionally, the fact that her baby is blind, and unless she is able to realize that his blindness is only one factor in his life, she will be unable to give him the care he should have, in the sense of fulfilling the needs of his personality.

No attempt is made to hurry the mother in adjusting herself to the difficulties she must face from now on, nor to minimize them. Instead, the case worker gives the mother continued opportunities to talk freely about her feelings and to tell of the disappointment, anxiety, and frustration she is suffering because her child cannot see.

The mother, and the father too, may at first refuse to believe that their baby is blind; and if they still refuse to believe it after a reasonable amount of explanation, the case worker may ask the doctor to explain his diagnosis to them again. She does this so that the parents will feel that it is natural for them to have many questions and doubts about their child's condition and that they have every right to discuss the situation thoroughly. If they wish to seek additional medical opinions the worker encourages them in this, so that they can feel that they have made every possible effort to give the child the best medical care.

In developing a program to meet the needs of blind preschool children under medical care at the Massachusetts Eye and Ear Infirmary, the social-service staff has been guided by the following principles:

1. Each blind child is an individual; his particular needs should be studied, and services offered accordingly.

2. If the blind child is to make a satisfactory adjustment to his handicap, the attitude of his parents, particularly of his mother, must be recognized.

3. The blind child will find his greatest sense of security in his own home, where he has his place in the family group.

4. All community services that are useful to the seeing child, such as convalescent care, foster-home care, child-guidance clinics, and nursery-school programs, should also be available to the blind child.

5. The mother of a blind child should be offered practical assistance in training the blind; such assistance should be timed according to the mother's ability to use it.

6. Further research and study is needed: (1) To provide norms regarding the development of the young blind child and (2) to determine what can help us most in understanding his emotional growth and in finding ways of treating his problem.

If the mother demands special attention for the child in the clinic, or is critical of the hospital's methods, every effort is made to meet her demands in order that she may know that the hospital has an interest in her as an individual.

At this time the father may be more articulate concerning the diagnosis than the mother, and he is likely to ask the case worker questions to which she can give factual answers.

While the worker is discussing the diagnosis with the parents, she observes the mother's emotional reactions and judges her ability to understand the doctor's direct statement. The worker also studies the ways in which the mother either expresses or disguises her feelings about blindness and notes her responses to the case worker's own services. The worker thus picks up clues to the mother's psychological make-up, and in this way determines how she can make her services most useful.

Case worker ready to help

The case worker offers no direct advice at this time. She tries to give the mother a sense of her complete interest and sympathy, and definitely tries to gain her confidence by accepting the mother's attitude without comment even if it includes great hostility to the child. The worker points out that it may take some time before the mother can feel differently. She shows that she is aware of the many difficulties the child's condition presents and suggests that the mother come to her to discuss any disturbing situations.

As the mother begins to accept the fact that the child is blind, the case worker stands ready to help her, but only as the mother herself decides that she needs help. Several months may pass before the case worker gives the mother any service other than the opportunity to express her feelings.

Sometimes a mother is able to accept the blindness of her child with a minimum of emotional reaction. Such a mother is usually aware of the difficulties met in caring for the child, and she turns rather soon to the case worker for suggestions regarding toys, feeding, and ways of stimulating the child in socialization.

Mrs. A, aged 40, is an example of this type of mother. She was very much

Paper given at the National Conference on the Blind Preschool Child, March 13–15 at New York.

disturbed about her baby's blindness, and doubted her ability to care for him. The doctor had therefore referred her to the case worker when the baby, Donnie, our patient, was 6 months old. The A's had six other children and the family relationships were excellent; Donnie had been fully accepted in the family group.

Mother's efforts successful

The case worker showed appreciation of the fine care Mrs. A was already giving Donnie, and showed that she realized that Donnie's progress was largely due to his mother's efforts. She encouraged the mother to continue his training in the sound way in which she had started, and told her she could consult the worker from time to time if problems came up.

When Donnie was almost 18 months old and could no longer be considered a baby, Mrs. A came to the hospital and told the case worker that her mother and other relatives were criticizing her for her methods of letting Donnie develop independence; for example, letting him experiment in walking, even though he would fall.

At this time Mrs. A was invited to attend a week-long educational program for mothers of blind preschool children—a summer school project. Here she found that her methods of caring for Donnie were approved by the experts at the school. As a result she was able to be more firm after she went home in holding to her own ideas even though her relatives criticized her.

The case worker suggested that a home nursery-school teacher might help Mrs. A with Donnie's training and give her instruction. Mrs. A readily accepted this service.

Mrs. A, as is usual with mothers who may be considered to be making a rather good adjustment, is aware of her own problems and of the resources she can use to meet them.

A mother who is antagonistic toward her blind child is easier to help than one who is overprotective. Regardless of how extreme the mother's antagonism may be, the case worker shows willingness to help her in any plan that seems to offer a chance that the mother may develop her latent feelings of love for her baby. If the mother requests that the baby be placed in an institution, the case worker discusses this possibility from the point of view of its meaning to the mother and the child, and in regard to the best place to send him and the length of time that she wishes him to be away from home.

One mother who requested that her baby be placed in an institution is Mrs. M. She is 24 years old, is not entirely happy in her marital relationship, and has three children under 3 years of age.

When the middle child, Jean, our patient, was 8 months old, the doctor referred Mrs. M to the case worker. During the first few months after the case worker was in contact with her, Mrs. M did not discuss Jean at all and did not seem to realize that the child was blind. She was giving the child only inadequate care, physically and emotionally, and the child was much under par physically.

Mrs. M became pregnant, and soon began to demand aggressively that she be relieved of the care of Jean, giving as her reason that she should have less responsibility during pregnancy. It was evident to the case worker that Mrs. M was strongly antagonistic to the blind child.

Since Mrs. M seemed to be unable to care properly for Jean, and since the economic status of the family was low, the case worker began to make plans to remove the child from the home.

Child-placing agency finds foster home

Great difficulty was encountered in finding a foster home that would accept a blind child. After months of effort, in which 18 different agencies were applied to, a child-placing agency finally arranged care for the child in a foster home.

The child-placing agency accepted responsibility for a long-time case-work service to prepare the mother to assume responsibility for Jean when her return home was recommended.

Jean has now been in the foster home for a year. A home nursery-school teacher visits her weekly to help the foster mother in training her. Her physical progress has been truly remarkable, and she has made some gains, but slowly, in general accomplishment.

A blind child needs mother love and secure family life even more than other children do.

Bernard's parents have always encouraged him to be active, even though he is blind.

Mrs. M now visits Jean weekly and shows some warmth for her. Whenever it is necessary for Jean to be taken to the hospital, Mrs. M accompanies the foster mother and takes responsibility for the child during the hospital visit, although at the time Jean was placed in the foster home Mrs. M wished to have nothing whatever to do with her.

In this instance it seemed desirable for the sake of the child, as well as the mother, to relieve the mother of all responsibility. It was evident that Mrs. M could not develop any feeling of warmth for Jean until she could feel that her burden was shared.

Sometimes the thinking through of actual arrangements for placing the child makes the mother aware of what giving up the child means to her, and she may withdraw her request before the plan becomes a reality.

Mrs. D, 18 years old, was one mother who did this. Mrs. D and her 3-month-old baby Jimmy came to the clinic accompanied by her husband's parents, in whose home the young couple were living. As the doctor discussed the baby's blindness the mother-in-law took complete control of the situation.

In spite of being only 18, Mrs. D showed considerable maturity in her interviews with the case worker and seemed to be capable of giving the baby adequate care. The case worker reassured her about her abilities, and Mrs. D indicated that she could care for the baby without any particular anxiety.

When Jimmy was 2, she came to the case worker, asking if there was some place where he could be placed for training. She said she did not wish to give him up, but her in-laws brought constant pressure on her in regard to his training, so that she had come to feel that his feeding and sleeping difficulties resulted from her poor care.

The case worker discussed Mrs. D's ways of handling her problems and told her that she thought her methods were sound and also that the problems she described were not restricted to a child who was blind but might be found in any child. She said to Mrs. D that it must be difficult for her to live in the home of her in-laws, and Mrs. D talked freely about the problems her living arrangements presented. The case worker spoke about the conflicts that frequently arise between grandparents and the child's own parents when both families share the same home. Before the interview was ended the case worker agreed to make arrangements for Jimmy's placement if Mrs. D was sure that this was the plan she really wished.

The mother decided to think it over, and when she returned for the next interview she withdrew her request for placement and discussed the advisability of living away from the paternal grandparents. The case worker lent support to this idea and the young couple now have a home of their own for the first time since their marriage. Jimmy is making excellent progress.

Overprotective mother difficult to help

Mothers who can only express feelings of overprotection for the blind child require a longer and somewhat more intensive treatment plan. They are likely to have strong feelings of guilt over having borne a blind child and are frequently inhibited in expressing any irritability toward the child. Such a mother cannot readily take advantage of many of the services which might be helpful to the child since she compels herself to assume complete responsibility for him.

Mrs. C is such a mother. Mrs. C was referred to the case worker when Richard, our patient, was 4 months of age. Mrs. C could think only in terms of the baby's care. She said that she was unable to enjoy any of her previous social activities because she did not feel she could leave Richard long enough to even hang her clothes in the back yard.

This mother had previously lived the life of a happy young married woman, enjoying Saturday night parties with other married couples. Therefore, the worker urged her to resume her previous recreation activities in spite of the fact that she claimed she did not now enjoy them.

When the baby was 14 months old he had to be hospitalized; and because of the mother's extreme anxiety arrangements were made for her to take a good deal of responsibility for his care in the hospital.

When Richard was 16 months old, Mrs. C was invited to join the summer-school project for mothers of blind children, but she was reluctant to do so. She was not yet ready to give up as much of the care of the baby as would be necessary in order to attend the lectures. However, when she was offered the opportunity to audit some of the lectures, she accepted. She would not be separated from Richard, but she was able to send her older preschool child to a nursery school; this gave her some relief from home responsibilities.

She has since indicated a willingness to have the home nursery-school teacher visit Richard, who is now 22 months old. Again the social worker did not insist upon the mother's use of a service before she was ready to accept it herself, but did make constant efforts to prepare Mrs. C to use the services as soon as possible.

The case worker is inclined to be fairly active in planning and offering suggestions to an overprotective mother when these activities seem to have some therapeutic value.

For example, if the case worker encourages the mother to release some of her child's care to experts, either by having a nursery-school teacher come to the home or by placing the child in a day nursery or nursery school, her approval and encouragement permit the mother to feel justified in freeing herself from some of her responsibilities.

The worker often suggests that some member of the family take more responsibility for the child, or that someone be employed to look after the child occasionally, or that the mother send the child to a nursery school even if she can only do this for one or two sessions a week.

Mother may be violently hostile

If the mother's urge to be overprotective is extreme, she cannot, of course, respond to such suggestions and will continue to take complete responsibility for the child. In such instances the case worker must be prepared to deal with rather violent expressions of hostility, which may occur when feelings of irritability toward the child are beyond the mother's tolerance point. When such feelings are expressed the mother may be shocked and frightened by her own behavior, but she can be greatly reassured if the case worker truly understands her reactions.

In dealing with a seriously maladjusted or neurotic mother it is important for the case worker not only to recognize the condition of such a mother, but also to be aware of her own limitations in dealing with this group.

Psychiatric treatment may help

It has been our observation that it is rare for a mother to break emotionally or physically in reacting to having a blind baby. Sometimes, however, a mother shows signs of disturbance that seem to indicate that she would make a more satisfactory and quicker adjustment if the services of a psychiatrist, as well as of the case worker, could be had. However, some of the milder forms of disturbance can be handled by the case worker, under the supervision of an experienced senior worker, with an occasional consultation with a psychiatrist.

In one instance the case worker had many interviews with a mother with neurotic symptoms, whom she was unable to help. When the mother developed physical symptoms for which no organic explanation could be found, the doctor recommended psychiatry. Although the mother was reluctant to acknowledge that she was ill enough for such help, she was finally able to accept psychiatric treatment, largely as a result of the interpretation and the support which she received from the case worker. She is now under a psychiatrist's care, and she continues to see the case worker in regard to finding educational opportunities for her child.

The case-work approach is a slow-moving one, and appreciable accomplishments cannot be quickly observed. It is necessary for the case worker to be constantly flexible and ready to change her goal for the child and his family as she increases her understanding of the mother's psychology and needs.

Parental attitudes are not clear-cut, and individual parents cannot arbitrarily be placed in different categories. A case worker's evaluation of the mother's attitudes is a continuous process. The worker must be on the alert to try to understand the mother's true feelings. Otherwise, encouragement of the mother's accomplishments may force her to aim at an ideal goal which she believes is expected of her, but which in reality she could not possibly reach. If the case worker sees that her own goal for a mother has been unrealistic, she must be ready to change the goal for one which is possible for the mother.

Case work cannot effect a complete personality change in a mother, but in many instances it can bring about slight modifications of her attitude, which will enable her to make decisions and see her way out of situations which have previously seemed impenetrable.

Frances cannot see the tissue paper, but she likes to feel it and hear it crackle.

If the mother is able to move positively toward a goal for the child and still retain her respect for her own decisions, the treatment has helped both the mother and child, irrespective of the total services offered by the agency which the worker represents.

Schooling for blind child the next step

As the child approaches school age the case worker should stand ready to cooperate with educational authorities in making an academic plan which meets the needs of the particular child.

The fact that the case worker is interested in the problems of these mothers and knows about the complications that may arise in connection with blind children, and that she is available when needed, gives them a sense of confidence and security—a feeling that they are not alone. They see the case worker as a symbol of continuity of interest and of service to them. The case worker's activities in general, with mothers who can accept the blindness of the child reasonably well, may be described as a liaison service between the needs of the child and community resources.

In summary, the case workers in our Social Service Department who deal with blind preschool children and their parents try to—

1. Give the mother complete acceptance and understanding of the way she feels about her problem as she sees it.

2. Assist in developing a warm and satisfying mother-child relationship.

3. Support the mother in her own decisions regarding what is best for her child unless there is evidence that she is entirely incompetent and her decisions would be actually harmful to the child.

4. Modify unfavorable attitudes of the mothers to the extent that they may become constructive in regard to the child.

5. Use any or all of the appropriate available resources in the community to encourage the child's training and development.

6. Recognize the limitations of case work and seek psychiatric assistance for mothers and fathers with serious emotional problems.

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State Plans for Maternal and Child-Health Services Show Expected Variations

Some data tabulated from plans for fiscal year 1947

CLARA E. HAYES, M. D., Senior Medical Officer, U. S. Children's Bureau

STATE PLANS for providing maternal and child-health services under the Social Security Act during the fiscal year ended June 30, 1947, showed as many variations as there are States. And by definition in the act, the term "State" here includes not only the 48 actual States of the Union, but also Alaska, Hawaii, Puerto Rico, and the District of Columbia. (The Virgin Islands also are now included, but were not at the time the plans for the fiscal year 1947 were prepared.)

The variations in the plans, of course, indicate the variations in the needs of the States for different types of maternal and child-health services. The Social Security Act recognizes the fact that conditions vary from State to State when it describes the purpose of the funds authorized for maternal and child-health services. The purpose, according to the act, is to enable each State to extend and improve its services, "as far as practicable under the conditions in such State."

Basically, of course, through the nature of the subject matter, the State plans resemble one another. Also a certain amount of uniformity is brought about by the fact that the Social Security Act makes certain requirements that each plan must fulfill in order to be approved.

One of these requirements, for example, is that the responsibility for administering the plan must be in the hands of the State health agency. Another is that personnel standards be maintained on a merit basis. Again, every plan must provide for extension and improvement of local maternal and child-health services administered by local health units. The act also requires that each plan provide for cooperation with medical, nursing, and welfare groups. And, in harmony with one of its expressed purposes, the act requires each plan to provide for development of demonstration services in needy areas and among groups in special need.

This analysis excludes all data on Emergency Maternity and Infant Care

In every State the annual plan for maternal and child-health services is prepared by the State health agency. The services that the health agency intends to provide for the purpose of promoting the health of mothers and children in the coming fiscal year are outlined in the plan, and the estimated cost of the various items of service is given. After the State plan has been approved by the Children's Bureau the Federal funds apportioned to the State under the Social Security Act for help in carrying out the plan are paid.

We are presenting here a partial summary of the 52 State plans for maternal and child-health services for the fiscal year ended June 30, 1947.

The plans from which these summaries were made provide for the expenditure of approximately $14,000,000 of Federal, State, and local MCH funds.

These plans were made some time before Congress increased the amount authorized by the Social Security Act for annual appropriations for grants to the States for maternal and child-health services. After the additional funds were authorized, the States revised their plans accordingly, and the final plans for the fiscal year 1947 included at least $2,000,000 more than the original ones, summarized here.

Fifty percent of the total was specifically budgeted for expenditure by local health agencies. A much larger percentage than this is actually expended for local services, since many States budget as "State" expenditures all, or a major share, of the cost of MCH services actually provided in local communities.

The communities where most of the services are provided are in rural areas. Only a small proportion of the program is carried out in counties that have any city of more than 100,000 population.

As for the types of services provided for, the plans show that payments to physicians, dentists, and hospitals for services to mothers and children account for more than $1,000,000 of the year's MCH funds.

When examining these figures, the reader should remember that not all the maternal and child-health services in any State are included, but only those provided under the auspices of the State health agency. In every State many public health services for mothers and children are provided under other public auspices. And in every State private agencies provide some services.

HOW MCH UNITS ARE SET UP IN HEALTH DEPARTMENTS

In every State the plans show that the health department has a maternal and child-health unit. In all but 12 States this unit is a separate division or bureau directly responsible to the State health officer. In 7 States the MCH unit is in the health department's division of preventive medicine, in 4, in the division of local health services, and in 1, in the division of medical administration.

In 16 States the maternal and child-health director is responsible also for the crippled children's program.

MEDICAL PERSONNEL

A total of 185 physicians were provided for in the 52 plans, 160 on full-time and 25 on part-time salaries.

In every State there is a State requirement that the director of MCH services be a physician; in all but one State the director gives full time to MCH services or to MCH and CC services. Three States reported the position of MCH director as vacant; in six there was an acting director at the time the plan was submitted.

Among 15 States there were positions for 18 assistant or associate directors; 6 of these positions were vacant.

In addition to these 70 positions for directors and assistant or associate directors, positions for 115 staff physicians were provided for among 36 States. These 115 positions included positions for 14 full-time and 4 part-time obstetric consultants in 17 States; 16 full-time and 3 part-time pediatric consultants in 16 States; 9 full-time maternal and child-health consultants in 6 States; 5 full-time and 1 part-time mental-

health consultants in 5 States; 1 part-time ophthalmological consultant; 1 part-time surgical consultant; 40 full-time and 6 part-time physicians not otherwise designated in 15 States; 2 full-time and 4 part-time obstetricians in 5 States; and 5 full-time and 4 part-time pediatricians in 7 States.

Postgraduate training for 19 physicians on State and local staffs, ranging from 1 month to 1 year in duration, was provided for in the plans of 16 States. In 8 States courses of from 1 to 6 weeks duration were planned for approximately 160 practicing physicians, principally those who serve in maternity clinics or child-health conferences. (After this analysis was made, practically every State provided for greatly increased training programs for physicians, nurses, and other professional personnel.)

MEDICAL SERVICES

FOR MOTHERS

Maternity clinics.—In 38 States, according to the plans, fees were paid to practicing physicians who conduct maternity clinics. On an hourly basis the fees ranged from $3 an hour to $10 for the first hour and $2.50 to $3 for each subsequent half-hour; on a clinic basis they ranged from $5 for a 2-hour clinic to $40 for a 1-day clinic, including travel time.

Seven States allowed 50 percent higher rates for specialists who conduct clinics. One State paid part-time salaries to obstetricians for conducting clinics.

Medical delivery care.—The plans of 16 States provided for payment for delivery by a physician, usually in limited areas or for special groups such as unmarried mothers.

Obstetric consultation. — Obstetric consultation was provided for in the plans of 23 States. In 12 States this service was on a case basis, the fee ranging from $5 to $15 for consultation in the home; from $5 to $10 for consultation in office or hospital, and from $25 a day plus maintenance and travel to $25 a half day plus travel. In the other 11 States, consultants were paid part-time salaries or were full-time staff members.

FOR CHILDREN

Child-health conferences.—All but 2 State plans provided for health supervision of children through child-health conferences. Some of the conferences were conducted by local health officers and others by practicing physicians. The latter were paid on an hourly or a clinic basis. The hourly rate ranged from $2.50 an hour to $10 for the first hour, $5 being the rate most frequently paid (14 States). In general, the higher rates were paid to physicians with special training in pediatrics.

Twenty-six States made additional payment for time spent in travel, the rates varying from the usual mileage allowed State employees to 25 cents a mile.

Medical examinations of school children.—Medical examination of school children was provided for in 14 State plans. The rate of payment to general practitioners for this service was usually on an hourly or a clinic basis; the rates ranged from $3.50 an hour to $10 for the first hour and $3 for subsequent half hours, and from $6 to $10 a clinic.

Diagnostic clinics.—Provision for diagnostic service for infants and preschool children was made in the plans of 8 States, in 4 of which children of school age also were included.

Medical treatment.—Medical treatment was planned by 13 States for infants and preschool children. In 4 of these States the service was limited to 1 county; in 2 States it was limited to premature infants; in 1 to refractions; in 1 to infants of unmarried mothers; in 1 to certain cases not eligible for emergency maternity and infant care; in 1 to pediatric clinics in 3 areas; in 1 State it was limited to 1 county and given only to children under 16 years of age at monthly clinics and to children in the home; in the other 2 it was State-wide for infants in need of care.

Seven State plans provided for medical treatment for children of school age. This was limited in 3 States to 1 county; in 2 States to care of visual defects; in 1 to pediatric clinics in 3 areas of the State; and in 1 to the treatment of school-age children through local and State funds.

Medical consultation.—Consultation by physicians was provided for in the plans, by 22 States for sick infants and preschool children and by 12 States for school-age children. In 9 States the service for infants and preschool children was given by personnel of State and local health departments; in 2 by both staff and consultants in practice; in 1 State by a member of the faculty of the university medical college; in the other 10 States part-time practicing consultants gave this service and were paid on an hourly or a case basis. In 6 of the 12 States providing consultation for school-age children the service was given by the maternal and child-health staff, in 5 by consultants in practice, and in 1 State by both.

HOSPITALIZATION

FOR MOTHERS

Hospital care during delivery was provided for in the plans by 17 States. In 10 the service was on a State-wide

basis, for unmarried mothers in 8 States, and for indigent patients in 2. In the other 7 it is limited to 1, 2, or a few contiguous counties or to a few communities.

FOR CHILDREN

The plans of 13 States included provision for hospitalization of infants and preschool children. In 3 of these States this service was limited to premature infants in certain areas. In 4 States it was limited to a single county; in 3 of these States it was a demonstration service. One State provided hospitalization for infants of unmarried mothers during their first year of life; 1 hospitalized certain infants not eligible for emergency maternity and infant care; 2 States, on a State-wide basis, hospitalized infants who were medically indigent, 1 made provision for this group in all parts of the State except in cities of 50,000 or more population, and another in 4 specific areas of the State.

Provision was made by 3 of these 13 States for hospitalization of school-age children in limited areas.

HOME DELIVERY NURSING SERVICE

Home delivery nursing service was available in 16 States, the plans indicated, in 2 of which it was limited to 1 county. In the others a very small number of patients in scattered areas were given this care, and in most it was on an emergency basis only. The fees paid to graduate nurses for home delivery service on a case basis ranged from $5 for 12 hours to $15.

SERVICES FOR PREMATURE INFANTS

Thirty-nine States included in their plans some service, in operation, for premature infants. Of the other 13 States, 5 described services proposed for the fiscal year 1947. Eight States included no service, either in operation or proposed, for premature infants. One described no program in its plan but has recently made a survey of hospital facilities for premature infants.

In the 39 States whose plans included services for improvement of care of premature infants, the services planned ranged from such comparatively minor efforts as postgraduate training for "a few" hospital nurses, or studies of the causes of prematurity, or in-service staff training, to State-wide programs including establishment of centers for the care of premature infants, hospitalization, and medical consultation; or provision of incubators, home nursing service, and hospitalization; or hospitalization and medical consultation.

Eight States had centers for the care of premature infants already in operation. Five of these States had 1 center only, 1 State had 2, 1 had "a number throughout the State," and 1 had 48 centers. Two of these States and 6 additional States included the establishment of centers as a service proposed for the fiscal year 1947.

Other types of service provided in the interest of premature infants included postgraduate training for State and local staff physicians and nurses, in 7 States; for hospital nurses, in 8 States; in-service training for State and local staffs, in 15 States; and instruction in the care of premature infants for practicing physicians, in 5 States. Consultation to practicing physicians was made available by 5 States, and nursing service in the home by 9 States. This nursing service in the home was limited in 3 States to areas having public-health nurses (2 cities); and to 4 counties in another.

Two States had demonstration services for the care of premature infants, and 1 State proposed to establish such a service during the fiscal year 1947. In 2 States technical advisory committees on prematurity had been appointed, and in another a medical conference for premature infants was conducted in 1 county.

DENTAL SERVICE

The organization charts of 45 States show dental units. In 26 States the unit is shown as a separate division responsible directly to the State health officer. The service is in the division of maternal and child health in 10 States, in the division of preventive medicine in 6, and under local health services in 3.

A total of 100 dentists, 85 full-time and 15 part-time, and 32 dental hygienists were included in the plans of 31 State programs. Thirty dentists' and 7 hygienists' positions were vacant when the plans were submitted.

Nineteen States provided payment of fees on either a clinic or an hourly basis to local practicing dentists for educational and diagnostic services at clinics. The fees varied from $3 to $10 an hour for the first hour, and from $3.75 to $6 for each additional hour, and from $5 for a 2-hour clinic to $28 for a 4-hour clinic. One State included travel time at the same rate paid for clinic service and 6 others allowed for travel at the usual State rate. The plans of 21 States provided for corrective dental service, some at clinics in dentists' offices and other clinics, and others by the hour in dentists' offices. Payment for this service ranged from $3 to $10 an hour, and from $10 for a half-day clinic to $28 for a clinic day, with an addition of from 50 cents an hour to $2 a clinic when dentists used their own materials.

NURSING SERVICES

The 52 State plans included a total of 331 nurses on the State health-department staffs, paid in whole or in part from MCH funds; 26 of these were directors and 6 were assistant directors; 82 were supervisory or advisory nurses. Eighty-six were consultants, including 20 consultants in maternal and child health, 6 in obstetric nursing, 2 in pediatric nursing, 24 in hospital nursing practice, 32 in public-health nursing, 1 in school health, and 1 in oral hygiene. Twenty-three were nurse-midwives, and 108 were public-health nurses not otherwise designated.

Nursing units were reported as being separate divisions responsible directly to the State health officer in 35 States. In the remaining 17 States, the nursing service was part of local health service in 12, in the division of preventive medicine in 2, under maternal and child health in 1, in the division of epidemiology in 1, and in the division of rural sanitation in 1.

Fees to graduate nurses were reported in the plans of 13 States. The rates of payment to graduate nurses for home delivery nursing service have been stated previously under "Home delivery nursing service." For postpartum care the fees ranged from $1 to $1.25 a visit, and for service at clinics, from 75 cents to $3 an hour and from $5 to $7 a clinic.

Thirty States provided postgraduate staff education for a total of 61 State public-health nurses and 87 local public-health nurses for periods varying from 2 weeks to 1½ years. Special training in obstetric and pediatric nursing, ranging in duration from 3 weeks to 2 semesters, was provided by 13 States for a total of 103 hospital nurses.

The major MCH contribution to nursing service is of course in local areas, where several thousand public-health nurses are paid wholly or partly from MCH funds.

NUTRITION

Forty-two State plans made provision for a total of 99 nutritionists on their staffs, including 9 designated as directors, 41 as consultants, and 49 as nutritionists. Another State employed a physician as director of nutrition service.

In the plans of 33 States the nutrition unit appeared in the division of maternal and child health and in 4 additional States the nutrition personnel were listed with maternal and child-health personnel. Nutrition service was in separate units responsible to the State health officer in 5 States; under local health administration in 3 States; under health education in 2 States, and under the division of preventive medicine in 1. The plans of 4 States did not give this information.

Postgraduate education was planned by 8 States for 10 nutritionists each, for periods of from 6 weeks to 1 academic year.

MENTAL HYGIENE

The plans of 14 States described mental-hygiene services in operation. In 4 of these maternal and child-health division alone conducted these services; in 3, separate mental-hygiene units within the State health departments conducted them; and in 7, mental-hygiene services were carried on by other State agencies and unofficial groups, under the supervision of the State health department. These included State psychopathic hospitals, State departments of mental health, a State board of mental hygiene, a State mental hygiene society, and a State medical college.

The MCH plans and organization charts of 11 States indicated separate units, sections, or departments of mental hygiene, 5 within the State health department, 1 in the department of public welfare; 5 were separate State departments.

Among the medical personnel previously enumerated are 6 physicians, who served in the mental-hygiene programs of 5 States, 2 as directors of mental hygiene and 4 as consultants. Four States included 5 psychologists and 3 psychiatric social workers in their programs.

New mental-hygiene services were proposed by 10 States, in 1 of which they were to be provided entirely by the maternal and child-health division, in 3 by the maternal and child-health division in cooperation with other official agencies; and in 6 by agencies other than the division of maternal and child health.

In the other State plans no mental-hygiene services were described, either in operation or proposed. In 2 of these, however, a division of mental health had recently been created within the State department of health but was not yet in operation. In 1 State a section of mental hygiene was being created within the State board of health, and in a fourth State, departments of health and welfare and community groups were preparing a plan for such services, to be submitted soon to the State health department.

MEDICAL SOCIAL SERVICE

More medical-social workers were being brought into the maternal and child-health service. Twenty-three States listed a total of 37 medical-social workers: 34 full-time workers and 3 others who divided their time between maternal and child health and crippled children's services. Of these positions, 13 were vacant at the time the plans were submitted, 12 full-time and 1 part-time. While these workers were concerned primarily with the emergency maternity and infant care program, they gave service also to the regular MCH program, and it is hoped that

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France Provides Health Services to Mothers and Children

ANNA KALET SMITH

International Cooperation Service, U. S. Children's Bureau

SINCE THE END of the Second World War in 1945, the rehabilitation of the shattered health of mothers and children in France has been a major concern for that country's Government. Although the particular needs of these population groups were recognized in France many years before the war, the facilities for safeguarding their health were admittedly insufficient in quantity and lacking in proper organization. In 1945 the Government made plans for reconstruction on a national scale of the resources for maternal and child health work, and it later placed on the newly organized Ministry of Public Health and Population the duty of transforming these plans into reality.

As a guide for carrying out this assignment an extensive body of legislation has set forth the principles and methods of a Nation-wide system of health services for mothers and children. This system, laying stress on the prevention of disease, is being gradually organized by utilizing the already existing facilities, with necessary modifications, and by developing new agencies where none exist. In this work the Ministry is aided by the social-insurance organizations, which, in France, as in other countries with well-organized social insurance, consider it financially advantageous to themselves to install facilities for preventive treatment with the aim of reducing ill health.

The organization of health work for mothers and for children under 6 years of age on a national scale was begun by the Government through a decree of November 2, 1945, and continued through regulations at various times in the next 2 years. This decree calls for division of the departments (administrative sections of the French territory) into districts. Each district must have 1 prenatal clinic for every 20,000 inhabitants and 1 child-health clinic for children under 2 years of age for every 8,000 inhabitants; also facilities for the diagnosis of tuberculosis and for the treatment of venereal disease, and a laboratory with the necessary equipment.

Protection of mothers

At the prenatal clinics a free examination is given to expectant mothers three times during pregnancy, and another within a month after confinement. The first examination, to be given before the end of the third month of pregnancy, is aimed at the detection of syphilis, tuberculosis, nephritis, heart disease, and diabetes. An X-ray examination of the lungs and a blood test for syphilis are required in every case. In the second and third examinations, given in the sixth and eighth months of pregnancy respectively, the urine is tested for albumin. Within a month after the birth of the child, the mother is required again to present herself at the clinic; this time she is given a general clinical examination, a pelvic examination, and whenever possible an X-ray of the chest.

A father must also be examined whenever this is considered necessary in view of the mother's state of health.

Treatment is available free of charge to persons covered by social insurance, who constitute an increasingly large majority of the French people.

An important element in the protection of maternal health is the maternity benefit introduced in France several years before the Second World War. Since the end of the war France has been going along with other countries, notably England, Sweden, and Soviet Russia, in expanding the maternity benefits. This was done in France under a law of August 22, 1946, so that at present the following kinds of benefits are available there:

1. Childbirth benefits, payable under specified conditions in two installments, after the birth of a child;

2. Family allowances for the second and each subsequent child, payable from the child's birth (or under certain conditions, from before the birth) until the end of the compulsory school-attendance period, and longer in some cases;

3. "Single wage" benefits for couples whose income consists of the wages of husband or wife only.

4. Prenatal benefits. The family allowances and the single-wage benefits may begin before the birth of the child. They are then called prenatal benefits and are paid from the day the pregnancy is reported to specified authorities. If the report is made during the first 3 months of pregnancy, the prenatal benefits are paid for the whole 9 months. The purpose of this is to encourage the mother to place herself under medical observation early in pregnancy.

According to a decree of March 6, 1947, the childbirth benefits may not be combined with the maternity benefits paid under the social-insurance law, and therefore the former are paid only to women who are not covered by social insurance. They are paid from the national treasury. The other kinds of benefits are limited to persons who are covered by social insurance, with the Government assuming a part of the cost. Also, the employed mothers of France benefit by the childbirth convention of the International Labor Organization, which is in effect in many countries of the world (it is not in effect in the United States). Under this convention French women are prohibited from working for a specified time near the childbirth period and, as a compensation for the loss of pay, they receive a part of their wages. This is paid by the social-insurance organizations to their members; smaller amounts are paid by the treasury to women not covered by social insurance. Nursing benefits are also provided by law.

If a woman fails to present herself for the required prenatal and postnatal examinations and to follow the instructions issued to her on the care of her own health and that of the child, she loses her right to the prenatal and childbirth benefits and to the premiums which are paid for regular attendance at a prenatal clinic. This, however, does not apply to the nursing benefits, which are canceled only in case the woman fails to take proper care of herself and the child as she is directed to by the social workers on the staffs of the prenatal and child-health clinics, who visit the mothers in their homes.

Protection of young child's health

An important factor in the safeguarding of child life is the child-health clinic, where the health and growth of the children are watched and the mothers are instructed in their care. Such clinics existed in France before the war, but at present efforts are being made to increase their number and to expand their work. Children less than 1 year of age are brought to the clinic for examinations at specified intervals. Regular attendance is rewarded by prizes in cash and in goods.

For every child brought for the first time to the clinic a health card is issued. This card must be preserved by the parents and presented at every subsequent medical examination of the child from infancy to the end of the school-attendance period. The results of the examination and the prescribed treatment must be noted on the card, according to regulations issued in December 1946.

A social worker who finds that the benefits paid to the mother are not used for the good of the child or that a child lacks proper care must report this to the departmental director of public health. If a child seems ill, the worker advises the family to call a physician, and if her advice remains unheeded she refers the case to a physician engaged in child-health services.

For the greater effectiveness of the health work, pediatricians are to be appointed to act as technical advisers in maternal and child health to the departmental director of public health. In addition, these pediatricians may be entrusted with technical control over public agencies and private organizations engaged in maternal and child-health work. According to a decree of May 22, 1946, each pediatrician acting in such capacity must have a definite territory assigned to him; one or more associates may be appointed for him.

Annual reports on the administration of the health services for mothers and for children less than 6 years of age in each department must be presented by the prefect to the Minister of Public Health and Population. The cost of administering the services is shared by the National Government, the departments, and the communes (the smallest administrative divisions of French territory).

As an attempt to coordinate the health work for children under 6 years of age a Supreme Council of Child Welfare has been organized in the Ministry of Public Health and Population under a decree of January 8, 1947. The membership of the council includes several public-health officials, two pediatricians, and one social worker. The council studies all questions referred to it by the Ministry and serves as a liaison among the Government agencies of France that are engaged in child-welfare work.

Protection of school children's health

School children's health has been claiming public attention for many years; and school medical services have been gradually introduced in a number of cities by the municipal governments. These efforts, however, have been inadequate in organization, and have been able to take care of only a small part of the school children. Therefore the Government has undertaken, as a part of its postwar rehabilitation, to organize a Nation-wide system of health services for all school children during the entire school-attendance period.

The foundation for this work was laid down in the decree of October 18, 1945, concerning the protection of school children's health; this decree was followed a year later by regulations translating it into action.

These regulations, issued in November 1946, stress prevention of communicable diseases, particularly tuberculosis, in view of the children's undernourished condition. They require that all children between the ages of 5 and 6 years shall be vaccinated and that they shall receive a physical examination, including examination of the mouth and teeth. This plan is followed in order to allow enough time for the correction of defects before the child enters school. Parents failing to present their children for such an examination are subject to a fine or imprisonment. Conditions requiring treatment are reported to the parents.

The results of each examination are noted on an individual health card, which is issued to each child and is kept by the school authorities while the child is attending school. After that it is turned over to the parents.

Children examined regularly

During the years of school attendance periodic examinations must be given to all school children. These examinations, like those given the child entering school, are free; but examinations by specialists and the laboratory tests are free only to children who are covered by social insurance; others must pay according to a fixed schedule.

The examinations are given by full-time or part-time school physicians. In each department these physicians are under the supervision of a chief school

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CHILDREN ARE CHIEF VICTIMS OF MIGRATORY-LABOR SYSTEM

Federal Committee Shows Way Toward Action

IN A COUNTY in the Southwest—a rural county of 5,380 square miles—a child-welfare worker was talking about her work.

"Much can be done," she said, "for this county's children. But not for the children in the cotton camps. Those families are shrugged off by the county, by the folks as well as the officials. Even the State finds the job of helping them too big. These migrants are the American untouchables! Yet these families—children included—pick the crop; without them the growers would be sunk."

"What can be done for these children?" Her thoughtful eyes seemed to look for an answer beyond her own county to the continental expanse of 48 units woven into one great people: Surely that people is equal to caring for the children who follow the million miles of criss-crossing highways, back and forth across State lines—spending their babyhood in trucks, in shacks, on the edges of fields; spending their childhood working with their parents on the crops that mature somewhere every month of the year. Following rich harvests, they lose the advantages that are supposed to accrue to American children from the Nation's agricultural and industrial wealth.

What can be done for these children who move from crop to crop?

The Federal Interagency Committee on Migrant Labor offers an answer. In a report, "Migrant Labor; a Human Problem," published by the Retraining and Reemployment Administration of the United States Department of Labor, that committee restates, in national terms, what that local child-welfare worker said about the children in the cotton camps of her county:

"A sizable segment of our population," it says, "through community and State neglect, has been robbed of so many normal American and human rights that it is almost unbelievable. Child labor, substandard living, and a padlock against education have destroyed the rights of children and drastically disturbed the integrity of family life among migrant workers. Estimates ranging from one to five million individuals comprise America's forgotten people of 1947, agricultural and industrial migrants. This equals the population of from 4 to 12 of our 48 States. Unorganized, . . . ineligible for educational, health, or welfare benefits, . . . migrants frequently find maintenance of even a minimum standard of living an impossibility."

The seriousness of the situation was recognized by the Twelfth National Conference on Labor Legislation, which was held in Washington late in 1945, representing 42 States, the District of Columbia, and Puerto Rico. This conference recommended organization of a Federal committee made up of the agencies having responsibilities toward migrant workers (these agencies are the Department of Labor, the Department of Agriculture, the Federal Security Agency, the National Housing Authority, and the Railroad Retirement Board). This committee, the conference decided, should study and report on working and living conditions and should work out a program to set standards for migrants equal to those set for other workers.

The committee was established in May 1946 under the authority of the War Mobilization and Reconversion Act of 1944. Now it has issued its report, describing actual conditions, and making recommendations in three parts: (1) Community and employer acceptance of their obligations toward migrant workers brought in for agricultural and industrial labor; (2) improved practices in recruiting, transporting, and placing migrant workers and in providing them with better housing, health, education, and welfare services; and (3) legislation, Federal, State, and local, to improve the working and living conditions of migrants.

"The chief victims in the families of migratory workers," says the report, ". . . are the children." Of the six "background discussions," which narrate the difficulties and the remedies for them, the focus for readers of *The Child* is "Child Labor and Education."

The report shows that much of the agricultural work these children do is as undesirable for them as the work that children did in factories until legislation forbade or regulated it. It shows the meagerness of current legislative protection, Federal and State, for these extremely young workers.

Frequent change from place to place makes these children feel uprooted and unwanted. Left to themselves day after day they may develop serious physical and mental difficulties. The committee recommends tax-supported day-care centers, with local people, employers, and workers joining to plan and to put thought and effort into making them work.

Specific about the education of migrant children, the report declares that not only do these children have a right to the services of schools in whatever community and State they reside in for short times, but the schools have a duty to plan services especially for these children, even though the services cost many dollars.

For example, a thorough service might mean the employment of an extra supply or reserve of teachers or tutors by State, county, or city school systems. Part of their duties would be to locate migrant children, to help them get into school, and to organize classroom groups when and where they were needed. These teachers would be educated to understand the hardships these children had suffered arising from their changing home life, their irregular schooling, undernourishment, and the fears and hostilities created by their being discriminated against in many of their temporary homes. Courses and school equipment for older pupils are also suggested.

If we Americans sincerely want to prevent a caste system from growing up based on a gross difference in education and the other necessities of childhood, the problems of the migrant family are the problems of us all.

Hilary Campbell

IN THE NEWS

California Youth Committee Studies Transient Youth

California is acutely aware of the problem of transient, migrant young people. During the war an increasing number of young workers flocked to the coast for war work, and the movement has continued and appears to be growing since the close of the war. Some are veterans who remember with pleasure their days here; others have followed their friends who are at work or in school.

Nonresident minors who get into difficulty are often passed on to the next community by officials too overburdened to handle the problems, and many hundreds are returned to their home communities in other States. San Diego, with the aid of State War Council funds, experimented in establishing a facility where these young transients could be held pending their acceptance by their own communities, whether within the State or without. The report concluded that communities, with the aid of State or Federal funds, could go a long way toward eliminating one of the most serious problems facing our Nation. It was concluded, also, that the transient problem is not only a local but also a State and Federal responsibility, requiring an intelligent and cooperative method of handling.

As the basis for a program for dealing with the young migrants, the California Youth Committee, appointed by the Governor in 1945, has received a grant of money from the Rosenberg Foundation of San Francisco to study the extent of the problem.

The plan of the study is to conduct surveys simultaneously in 14 cities on main routes into the State or in areas where present reports indicate that such youth are congregating. These are Los Angeles, San Diego, San Bernardino, Long Beach, Riverside, El Centro, Bakersfield, Fresno, Stockton, Sacramento, Redding, Salinas, Oakland, San Francisco. Information will be obtained regarding migrant or transient youth as they make contact with private and public youth-serving agencies. By repeating the census several times during the next 6 months, it is hoped that a picture of the problem can be secured, which will give the Governor and the California Youth Committee information and suggestions regarding plans for the adequate care of these young newcomers.

Mary Bishop Perry, regional consultant, Child Labor and Youth Employment Branch, Division of Labor Standards, United States Department of Labor, is on leave of absence to head the survey. Dr. Robert A. McKibben, chairman of the California Youth Committee, and Mrs. Paul Eliel, chairman of the executive committee of the Committee for the Study of Transient Youth, are working closely with the developing plans. State and local agencies dealing with youth will cooperate in the study.

Mary Bishop Perry

Kansas Council for Children Active

A Kansas Juvenile Code Commission of five members has been authorized by the legislature to study the laws of the State relating to children and to report their findings and recommendations, in the form of drafts of bills, to the Governor and the legislature by January 1949. The authorization specifies that this study and compilation of facts shall include "dependent, neglected, delinquent, emotionally and mentally disturbed children, and problems related to children in this State." The commission is also to "investigate the causes, prevention, and cure of juvenile delinquency." The sum of $12,500 was appropriated for the 2 years' work of this commission.

The Kansas Council for Children was active in the support of this and other legislation affecting children. Improvement of marital laws, the requirement that bread be enriched, and various desirable hospital and medical measures were passed. The vigilance of the council helped prevent the passage of two measures that would have separated certain work for children from the child-serving agencies. The first of these was a bill to shift the children's institutions to the State Board of Administration. The second, which perhaps would have been even more damaging, was a proposal that juvenile homicide cases be placed under the jurisdiction of the District Court.

Among other work of the Kansas Council for Children this spring was cooperation with State public and private groups in planning and executing a conference on exceptional children, to which were invited an administrator and a classroom teacher from each school system in the State, workers in social and health services, and the faculty of the teacher-training institutions.

Colorado Improves Services for Children

The Colorado Legislature in April 1947 passed a bill creating a children's code commission of five members to make a careful survey of child welfare and to report to the Governor and the general assembly by November 15, 1948. This is another step in the steady march of legislation and development of services in behalf of the children of the State.

Colorado has persistently improved its provision for services for children. After the Colorado White House Conference of 1932, the State Department of Public Welfare, with a child-welfare division, was established. As a result of State and Federal cooperation made possible by the Social Security Act of 1935, marked improvement in certain provisions for general welfare and for the health of children took place.

Ten years later, the 1942 Colorado White House Conference on Children in a Democracy adopted a report of a survey of conditions and services affecting children, which was made by 10 committees, including over 300 qualified lay and professional leaders. These studies revealed many "serious gaps in the program of the State for the protection and education of its children," such as insufficient health agencies, recreational facilities, and libraries accessible to rural youth; insufficient laws regarding supervision of the care of children in foster homes and of child adoption and placing; inadequate educational programs in the State homes for defective children and in the State reformatory, and inadequate regulation of employment of minors.

Soon after the war, interested citizens raised approximately $800 to aid the University of Colorado in a study of children's laws. The creation in 1947 of a children's code commission by act of the legislature is the next step in this ever-advancing program. The code commission is instructed to study the needs of children in matters which can be controlled or improved by legislative enactment and to consider also the existing laws, together with such "changes in the laws and additions to them as may be needed to embody the best experience on those subjects both in relation to ameliorating the conditions of children and preventing conditions which adversely affect the welfare of children." A sum of $7,000 has been appropriated for the expenses of this code commission.

Stella Scurlock

For Better Statistics on Rheumatic Fever

Noting that rheumatic fever has "vast consequences and social effects on the health of the child and the adult," the Twelfth Pan American Sanitary Conference, held at Caracas, Venezuela, has approved a recommendation that physicians be required to report cases of this disease to the health authorities of their community. The recommendation was made by the Uruguayan delegation at the suggestion of the Pan American Sanitary Bureau, as a result of a study of rheumatic fever made by the American International Institute for the Protection of Childhood.

Nebraska Legislative Council Studies Child-Welfare Laws

The Nebraska Legislature in February 1947 passed a resolution recognizing the desirability of clarifying and strengthening the State laws to protect the interests of children and to promote their welfare.

It directed the legislative council to continue its study of Nebraska child-welfare laws, to compare them with those of other States, to seek the cooperation of public and private agencies and of individuals concerned with the welfare of children, and to hold public hearings to obtain the views of those interested.

The council is directed further to report to the 1949 legislature its findings on existing laws and its recommendations for the clarification of existing laws and for new legislation needed for the benefit of children within the State.

• CALENDAR

July 14–17—Fifth International Congress of Pediatrics. New York. This international congress was to have been held in Boston in 1940, but had to be postponed because of the war. Further information from the secretary, Dr. L. Emmett Holt, Jr., Bellevue Hospital, New York 16.

Aug. 4–8—American Dental Association. Boston.

Aug. 27–29—National Association for Nursery Education. San Francisco.

Sept. 8–12—Third American Congress on Obstetrics and Gynecology. St. Louis.

France Provides Health Services to Mothers and Children

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physician, who is himself responsible both to the educational authorities and the public-health authorities of the department.

The results of all examinations must be reported at definite intervals to the specified public authorities.

Special school health centers to be established

Under the regulations of November 1946, all medical and dental examinations are to be given in special "school health centers," one or more of which must be established in designated cities and towns. At least one trained social worker must be attached to each center.

Supervision over the health of the teachers and other members of the school staff who come in contact with the children was ordered to begin October 1, 1947.

A joint project

The cost of examining the children, teachers, and other members of the staffs is borne jointly by the National Government, the departments, and the communes. Aid is given by the National Government to communes for the installation of school health centers.

Annual inspection of all school buildings, public or private, must be made by the local school physician, and reports sent not later than December 31 of each year to the prefect of the department.

The school health work is administered jointly by the Minister of Education and the Minister of Public Health, with the participation of a national advisory commission, which was to be appointed under regulations issued in March 1947.

These plans and directives are being gradually put into operation with funds that were appropriated by law for the first quarter of 1947.

SOURCES:

Journal Officiel de la République Française, from October 1945 to March 1947. Bulletin Législatif Dalloz, January 1946 to March 1947; Bulletin du Ministère de la Santé Publique et de la Population, Nos. 1, 3, and 8, 1945 and 1946.

State Plans for Maternal and Child-Health Services Show Expected Variations

(*Continued from page 9*)

when emergency maternity and infant care is discontinued the medical-social personnel will remain to give full time to maternal and child-health services.

HEALTH EDUCATION

Twenty-one State plans provided for employment of a total of 27 health educators. Of these, 4 were designated as directors, 1 as an assistant director, 9 as consultants, 3 as public-health educators, and 1 as school health educator; 9 were not designated. The services of these workers vary greatly. Some specially qualified workers function entirely as school health educators, working closely with State and local departments of education, teacher-training colleges, and the public schools, in the preparation of curriculums and special materials for the improvement of health teaching. The work of others is limited entirely to public-health education, which consists of the preparation of material used through the various publicity channels and in keeping the public informed of the service and progress of public-health agencies. A third group combines these two functions.

This summary can give only a limited idea of the maternal and child-health services that the States provided for in their plans for the fiscal year 1947. It represents only such data as can be tabulated. The fascinating details of how these services are made available to the individual mother and child are given in the plans as prepared by the States. The plans show also the relation of these services to the total State and local health program.

Some of the gaps in service are due, not to lack of interest or of money, but rather to lack of trained personnel. One of the fields in which progress has been especially retarded by this condition is mental health. It is evident that a program of training is needed in a number of fields before enough competent personnel can be obtained to provide the health services that the mothers and children need.

Reprints available in about 5 weeks

FOR YOUR BOOKSHELF

WHEN I WAS A CHILD; an anthology, by Edward Wagenknecht. E. P. Dutton & Co. New York, 1946. 477 pp.

Early childhood memories, as Walter de la Mare says in his introduction to this collection of them, of people who not only are exceptional but who can write, make fascinating reading. Not only that, but they offer us a wonderful opportunity to observe the workings of children's minds. Even making allowance for the fact that such recollections are seen through the colored glass of the writer's later experiences, we get some intimate flashes of insight into what it is like to be a child—something any adult who has anything to do with children welcomes eagerly.

Forty-one authors are gathered here, representing a wide range of background. There is the lonely figure of little John Ruskin in the garden "decked . . . with magical splendor of abundant fruit, fresh green, soft amber, and rough-bristled crimson . . . clustered pearl and pendent ruby"—different from the Garden of Eden in that "in this one, *all* the fruit was forbidden." There is Middleton Murry, who "could not sleep without a knotted towel for company," to protect him from the frightful night terrors to which he was subject.

When Eric Gill's mother accused him of something he was not guilty of, he was flabbergasted. For if with one's own mother it was impossible to put the thing right . . ., what frightful things might be possible in the world outside where no sympathy and understanding could be drawn upon. . . . It seemed as though the very earth were reeling and insecure."

Marjorie Bowen gives us another picture of insecurity, that of the bewilderment of a child whose parents were separating. Of her mother she says, "When I was with her I always seemed to be naughty." Her baby sister's "sweetness and beauty were supposed to be in painful contrast to my plainness and villainous disposition." Of her father, whom she adored, she mysteriously saw less and less.

Mary Ellen Chase, recalling a New England Sunday in the nineties; Kathleen Coyle, coming home to her Roman Catholic mother a devotee of the Salvation Army, after being hospitalized in Glasgow; Lizette Woodworth Reese, evoking the very smell and taste of Christmas—the "thick, sugar-topped loaves, fat and black with raisins"; Eleanor Hallowell Abbott, explaining, from Longfellow's lap, that she liked his lines about Mr. Finney's turnip better than his "The Psalm of Life"—this is the world of childhood, with which we all need to renew acquaintance in order to narrow the gap that separates us from those for whose safety, happiness, and welfare we all work. This is "child psychology" distilled into something rich and rare.

Marion L. Faegre

YOUTH ORGANIZATIONS IN CANADA; a reference manual, by George Tuttle (1946. 27 pp. $1.50); YOUTH AND RECREATION; new plans for new times (1946. 220 pp. $1.25); YOUTH AND HEALTH; a positive health program for Canada (1946. 93 pp. $1); YOUNG CANADA AND RELIGION (1945. 114 pp. $1). Prepared for The Canadian Youth Commission. The Ryerson Press. Toronto.

This series includes also "Youth Challenges the Educators," and "Youth and Jobs for Canada," both of which were discussed in *The Child*, June 1946 (pp. 192–193).

THE BLIND, by Robert B. Irwin, LL. D. American Foundation for the Blind, 15 West Sixteenth Street, New York 11. Revised 1947. 12 pp. Includes a section on Educational Facilities for Blind Children.

Reprints Available

A limited quantity of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had free.

Avoiding Behavior Problems. By Benjamin Spock, M. D. *Journal of Pediatrics*, October 1945.

Some Observations on the Canadian Family Allowances Program. By Edward E. Schwartz. *Social Service Review*, December 1946.

Nursing Care of the Premature Infant. By Elgie M. Wallinger, R. N. *American Journal of Nursing*, November 1945.

Parental Rejection of Crippled Children. By Norman Westlund, M. D., and Adelaide Z. Palumbo. *American Journal of Orthopsychiatry*, April 1946.

Pediatrics and Public Health. By Herbert C. Miller, M. D. *News Letter of the Kansas State Board of Health*, October 1946.

THE OPERATION OF HOISTING APPARATUS. Report No. 7 on occupational hazards to young workers. Child Labor Series No. 11. Child Labor and Youth Employment Branch, Division of Labor Standards, U. S. Department of Labor. Washington, 1946. 37 pp.

This report, which was made available in mimeographed form in May 1946 by the Children's Bureau, served as the factual basis for Hazardous Occupations Order No. 7, issued under the child-labor provisions of the Fair Labor Standards Act of 1938. The investigation was made by the Bureau's Industrial Division, which under the President's Reorganization Plan No. 2 of 1946 has since become the Child Labor and Youth Employment Branch of Labor's Division of Labor Standards.

Child Study Association of America Lists Pamphlets

The following pamphlets and reprints, among others, are available from the Child Study Association of America, 221 West Fifty-seventh Street, New York 19, N. Y., at the prices indicated: Discipline Through Affection, by Arline B. Auerbach (10 cents); Discipline, What Is It? by Helen Steers Burgess (15 cents); Looking at the Comics, by Josette Frank and Mrs. Hugh Grant Strauss (20 cents); Preadolescents: What Makes Them Tick, by Fritz Redl (20 cents); The Comics as a Social Force, by Sidonie M. Gruenberg (10 cents); The Kind of Parent Teachers Like, by Irvin C. Poley (10 cents); Today's Children—for Tomorrow's World, by Arline B. Auerbach (30 cents); What Makes Good Habits? (15 cents); When Children Ask About Sex, by the staff of the Child Study Association (25 cents).

●

Our new volume of *The Child*, volume 12, starts this month with a healthy, happy baby on the cover. Aiming to have every child born in the United States as fine as this one, all the States, in cooperation with the Federal Government, are providing maternal and child-health services under the Social Security Act. The photograph is by Philip Bonn for the U. S. Children's Bureau.

Other credits:

Page 3, Upper, Library of Congress photograph, by Arthur Rothstein for OWI; lower, photograph by Philip Bonn for U. S. Children's Bureau.

Page 5, photograph for U. S. Children's Bureau.

Pages 7–9, sketches by Alba Leiss.

Page 11, Library of Congress photograph, by Howard Hollem for OWI.

WILL YOU HELP?

I have just come back from Europe after looking in the faces of hundreds and thousands of big and little children. They were children in Poland, Czechoslovakia, Yugoslavia, Greece, Italy, and France. They were children who passed me on the streets, children in schools, clinics, hospitals, in war orphanages and other child-care centers.

I went to Europe to find out for the International Children's Emergency Fund what these children most desperately need. I know, now, what that is.

The children in the cities and villages of these war-stricken countries need many things, but of all their needs milk comes first. They need milk in great quantities. They need it now. Since the war, almost the only milk they have had has come from UNRRA. But UNRRA's food has already stopped coming in many places. On June 30, it will cease altogether. Unless great volumes of milk start to move from countries such as ours that are lush with supplies, there are going to be millions of children who may be brought down to starvation levels that were all too common before UNRRA started.

Milk is first; then come many other needs. Shoes, for instance. I never saw so many poorly-shod or barefoot children in a city as I saw in Warsaw. Drugs and medical equipment are seriously lacking. Children's hospitals need beds and bedding. Doctors and nurses need coats and uniforms. Almost everywhere I went I heard a plea for diapers. "Ship us bolts of cloth," one medical director asked, "and we will make up the diapers ourselves." In many places there is little or no cod-liver oil.

This is the report I brought back to the International Children's Emergency Fund. This fund was created by the General Assembly of the United Nations to be the channel through which contributions from governments and citizens can flow to the relief of children in war-stricken countries.

The fund will use its money to buy foods, medical supplies, and other things, and help these countries extend and improve their health programs for children. Because the needs are so great, a priority plan for relieving them has to be agreed on. As a step toward such a plan, I went abroad to learn what children's workers on the job say are the most urgent needs of the children.

Already the United States Congress has authorized a minimum of $15,000,000 and a maximum of $40,000,000 as this Government's contribution to the fund. A number of other countries, including Australia, Canada, New Zealand, Norway, Switzerland, and the United Kingdom have agreed in principle to support the fund and are now deciding on how much their contribution can be. After the governments have made their decisions, an appeal will be made to citizens throughout the world to open their purses and pour out their money for the rescue of the more than 3,000,000 war orphans and the many other millions of children on whom the war has left its deep scars.

I know, when that appeal is made to the fathers and mothers and children on this side of the Atlantic, there will be no hesitation, no begrudging. Even though few of our people have seen the stunted bodies, the listless spirits of the little boys and girls of Europe who need our help, our imaginations are quick and our hearts are large.

Martha M. Eliot

MARTHA M. ELIOT, M. D.,
Associate Chief,
U. S. Children's Bureau.

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THE CHILD

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A FOSTER CHILD NEEDS HIS OWN PARENTS

ALMEDA R. JOLOWICZ, Supervisor of Training,
Nassau County Department of Public Welfare, Mineola, N. Y.

EVERY experienced child-welfare worker is sometimes tormented by doubts of the efficacy of foster-home care for a child who must be cared for away from his own home. In fact, a worker viewing the end result of years of foster care for a child will sometimes remark that the child could not have been much worse off if he had remained in the home from which he was removed.

It is true that many children in foster homes have grown up happy and well adjusted; these help to preserve our faith in what we are trying to do. And some are never able to adjust at all.

There are other children, however, who for some years after going into a foster home seem to be well adjusted to it until adolescence. At about that time the boy or girl becomes more than normally moody, irritable, and defiant. Often such a youngster, who for years has had only a desultory contact with his own kinfolk, or none at all, will suddenly go to great lengths to look them up, and sometimes will even begin to act like one of his parents.

One such child is Mary, who was placed in a boarding home at the age of 4. Her father had left home some time before, and no one knew what became of him. Her mother, a promiscuous woman, had often entertained men at home even before her husband left her. This continued afterward, and there is no doubt that the child knew much of her mother's intimate affairs.

Mary adjusted fairly well to her foster home, was sweet, obedient, never a real problem. To everyone's relief the mother visited her only rarely. The child seldom, if ever, asked about her mother. The social worker rarely mentioned the mother to the little girl, and the foster mother did so only when she expressed her disapproval of the mother's visiting.

At 14 this well-behaved, sweet child became "boy crazy" to a rather alarming degree, and when the foster mother finally discovered some notes written by the girl which in her opinion were vulgar and seductive, the comfortable years in the foster home came to an abrupt end. Because the girl's behavior seemed to be patterned on her mother's, no one will ever convince the foster mother that blood is not thicker than water or that her years of care were not wasted.

Another example is John. Born out of wedlock, John lived in several successive foster homes during his first 3 years. Then he became settled with foster parents, who lived on a farm, and there he remained throughout childhood. The foster parents did not adopt him. In all these years his mother never visited him, and the boy never asked about her, though he knew the foster parents were not his own, and no one mentioned the mother to him.

When John reached adolescence, behavior difficulties appeared, which did not seem important, but which gradually grew more serious. He refused to do his chores and would leave the farm for absences during which no one knew where he was. He said that he did not have to obey his foster mother, toward whom he had previously been affectionate, and he began to ask many questions about his own mother, whom he could not remember having ever seen. Finally, the foster parents asked the agency to remove him, and a series of unsuccessful placements in wage and work homes followed.

Child influenced by absent parent

Such stories make one stop and think. Could a mother who apparently had been forgotten by her daughter have more effect on the daughter's life than the foster home? Could a boy who had never known his own mother be so influenced by her that after a dozen years with kind and loving foster parents he entirely rejected them? Is there something in the parent-child relationship that gives a parent control over the child even in absence?

To answer these questions we have to go back to a misconception upon which some — perhaps many — foster-home placements have been made. That is the mistaken idea that one has only to remove a child from a bad environment and place him in a good one to make him into a respectable citizen. This concept of the child's being a pliable piece of material, which can be molded into a desirable finished product by proper training and environment, is part of the historical development of the philosophy of child-care programs.

In this philosophy behavior was the

Tom's foster parents have had an enlargement made of a snapshot of his own parents, and Tom and his foster mother are showing it to the social worker. Both the worker and the foster parents are aware that a child needs to keep in touch with his own parents.

Condensed from paper given at the New York State Conference of Social Welfare, New York City, November 1946. Copies of the complete paper may be had by writing to the U. S. Children's Bureau.

result of habit, and habit the result of training. That a child already had tendencies that would direct his behavior, that a child had an inner life that might be far more important in the development of his character than his outer life, were concepts far in advance of the early workers.

We know now that every child coming into foster care must be regarded as an individual needing help, and that there should be no place in our thinking for generalities about good and bad environments.

Good environment not enough

We now know that a child may be placed in a good environment and not be affected by it. Nowhere is the expression, "you may lead a horse to water but you cannot make him drink," more apt than in relation to a child who is picked up from one setting and dropped into another.

The reasons why foster-home placements sometimes fail are many. To cover them all one would have to touch upon the way the foster home is studied by the agency, the matching of the home and the child, the preparation of the home for the child. One would have to consider the parent who never will be able to accept with good grace the placement of her child in foster care, also the many aspects of the inner life of the child. This paper deals only with that part of the child's inner life that has to do with his relationship with his parents.

If placement is to be more than just transferring a child into a good environment, we must realize that the child does have an inner life, in which he maintains a parent-child relationship. Secondly, we must accept the evidence of numerous cases that physical separation of parent and child does not necessarily interfere with the parent's influence upon the child. On the contrary, the separation may lead to the child's idealizing the parent. This may become clearer if we go back to our two stories.

Let's begin with Mary. Psychiatrists tell us that it is in the preschool period that little girls really become feminine. It is not at all uncommon to hear an adult say of a 5- or 6-year-old girl, "What a little flirt she is" or "she's already a little woman." We know also that a little girl gets her concept of womanhood from her mother. The child's growth in the direction of becoming like her mother is marked by two-way feelings, of love and hatred. The little girl admires the mother and is jealous because she has characteristics now denied the little daughter.

These conflicting feelings cause tensions in the little girl which may be eased if she remains under the loving care of her mother. However, if the little girl is removed from her mother, the child still loves her, and the yearning to be loved by her continues. But with this is a natural resentment, for she feels that the mother did not love her enough to want to keep her.

Child is loyal to own mother

In the foster home the little girl finds another mother who is kind and loving, and the child accepts this substitute love and appears to adjust well to this new home. But what about the real mother? Whenever she makes one of her infrequent appearances, or whenever the question of the little girl's going home for Christmas or a week end arises, the foster mother shows, directly or indirectly, her disapproval and her unmistakable opinion that the mother is a decidedly poor influence.

In the meantime, what has the social worker been doing? She has been skirting the subject of the child's mother, which is as bad as the open criticism by the foster mother. This action probably arises from the fact that we should like children to have ideal parents, and when we find a most un-ideal lot and see the grief they cause their children, we cannot bear it. We avoid the subject of the disreputable mother to save our own feelings, and we overlook the fact that if we talked to the child about her we should be talking about something that the child knows more about than we do.

And so the little girl gets the impression that everyone thinks she should not love her mother. However, her yearning to love and be loved by her mother continues. She condemns her own resentment and is aware only of her loyalty and of a strong need to defend her mother. Love and hatred then are both repressed, which simply means that they have gone underground, where, unknown both to the child and to the people around her, they continue to be active in forming her personality. The little girl, as she grows up, seems to get her mother back by becoming like her. At adolescence, boy-crazy behavior shows up, and now everyone says, "Isn't it too bad, she's become just like her mother. And after all we've done for her!"

Robert is one of the many foster children who have grown up happy and well-adjusted. His foster parents have always encouraged him to keep in touch with his relatives.

But we find that one important item was missing from the "all we've done." That was giving the little girl a chance to talk about her mother. Mary should have been not only allowed to ask questions but even encouraged to do so.

Someone should have acknowledged to her that of course she loved her mother. Almost everyone loves his mother; there's something wrong if you don't, not if you do. Once the child learned that no one would condemn her for loving her mother, and that she no longer had to defend her against criticism, she should have been encouraged to talk freely, even to tell of her resentment and anger that her mother had let her down, had failed to be the kind of mother that she should have been. Talking would have released some of the child's tensions and left her freer to pattern her life after that of the foster mother's.

Now take John, who had never known his mother. Did she influence his life so much that he lost the only home he ever had? Can you imagine that a child can grow up in a home that he knows is not his own, and never, never wonder about who he is? Who were his mother and father? What did they look like? Does he look like them? What kind of people were they? Why didn't they keep him? Why do they never come to see him?

Is it not logical to think that at adolescence John's normal drive to be free of the restrictions set by adults was stepped up by his resentment because these people were not his own? Why should he obey them? They weren't his own parents. After all, what did he owe them? That may not be logical reasoning, because maybe he owed them a lot, but on whom else can he get rid of the resentment that comes not only of not having parents but of not even knowing anything about them?

Barring the rather obvious point that maybe this boy needed to be adopted instead of being kept at loose ends in boarding care, would it not have been better for the social worker to have talked with him from time to time, explaining that his mother had not been able to care for him, that she had wanted him to have a good home with a father and mother, that she had asked the social worker to find one for him, and that these parents were like real parents to him? With some of his longing to know about his own parents fulfilled, his wish to belong, his loyalties, and his feelings of love might have been securely moored to his foster home.

What can we learn from these two stories? First, they reaffirm what we already know, that the child continues to maintain some kind of relationship with his parents long after being separated from them. This relationship may be one that exists entirely in the child's inner life, with no counterpart in reality. In it may mingle love, anger, disappointment. Whatever these feelings are, part of their power over the child comes from the fact that they are hidden. Feelings that have no outlet have a strong effect upon personality.

To this point we have been developing three ideas: (1) Elimination of a parent from the life of the child does not necessarily eliminate that parent's influence upon the child. (2) Strong conflicting feelings about the parent may be present in the child. (3) The strength and influence of these feelings are increased by their concealment.

How social worker can help

Now what meaning do these facts have for the everyday practice of a social worker? First of all, social workers should take the initiative in helping children work out some of these conflicts about their own parents. What Anna Freud calls "the images of the parents" must be kept clear in the child's mind, even if a parent is dead, or committed for life to a hospital for the insane, or if of the parent's own volition he is completely out of the child's life, as in the story of John.

Only in this way will the feelings attached to his curiosity lose some of their strength; only in this way will some of the sting be taken away; only in this way can the longing for his own people be satisfied in some measure and his longing to be loved directed toward the foster parents.

There are three ways by which the social worker may help the child in this.

First is talking with the child about the parents. This is not easy. But the difficulties lie solely within ourselves, and most of them center around fear. We are afraid to hear children speak ill or disrespectfully of their fathers and mothers. Criticism of parents not only goes against our upbringing but arouses in us the fear that if we let the child criticize his parents openly, we are teaching him that he may be critical of any authority. This might mean he could react in the same manner toward the foster parents, and ultimately toward all law and authority.

These fears are groundless. On the contrary, if a child has resentments and disillusionments because adults have neglected him or pushed him around, it is reassuring to find in the social worker a person who agrees openly with him that his life has been hard and who lets him know that she doesn't blame him for feeling as he does. Such a person can help reestablish his faith in adults.

Strange to say, we sometimes fear the child's love for a delinquent parent. We are afraid of this love because we all know that a child often becomes like the person he loves. On the surface it seems that if we tell a child that of course he should love his mother or father, we are telling him to become like the parent. Again this need not be so.

Another reason why it is not easy to talk to these children about their parents is that we are afraid to talk about the parents' behavior. Think of the sex offenses committed by some parents. Think of their laziness; think of their filth; think of their alcoholism.

We could have greater peace of mind about the parents' behavior if we could see beyond the behavior to the person, and could see that his behavior represents his fumbling attempts to be happy. In this respect he is no different from ourselves.

Child is not deceived

Only if the social worker sees beyond behavior to the person, only if her feelings about the child's parents are warm and friendly, will she be able to talk with this child about them. If she attempts to sound broad-minded while she is really sitting in judgment, if she is afraid of the parent or of his influence, if she attempts to cover critical feelings with a veneer of tolerance, the child will know it. In that case, he will simply add her conflicts to his own.

It is this "how" of talking to the child that is hardest. It must be a matter-of-fact "how," in which liking for the parent and acceptance of the child's two-way feelings are implicit.

Once we have mastered the "how," the "what" becomes easier. First, we must tell the truth. A child can stand the truth when *with it* goes the worker's sincere interest in the child's happiness, her warm regard for his parents, and her recognition of his hardships. What we tell him will depend also upon what the child tells or asks us, provided our manner encourages him to ask questions.

Though it seems to be a paradox, a child can give up the past more easily if he can keep part of it with him in the sense that he is free to talk about it. He can loosen his bond with his parents more easily if he is not called upon to abandon them entirely.

The "when" of talking to a foster child about his parents, the timing of our telling, is particularly important. One cannot avoid talking about the parents at the time the child is placed in the foster home, when the reasons for placement are being explained, but

Susie's mother has always been welcome at the foster home. After one of her frequent visits, Susie and her foster mother and foster sister are taking her to the bus stop.

one should give only as much information then as the child can digest. As the child becomes more secure in the new home, more details about his parents can be given him. Age is another factor to be considered: what one would tell a 5-year-old would be very different from what one would tell the same child at 15. And we cannot tell a 5-year-old about the mother or daddy who went away and then drop the subject forever after. We must keep it open and help the child to formulate his own questions, which change as he matures.

In addition to helping the child ask questions about his parents, the worker can help him feel that his parents are not shut out of his foster home by seeing that he has photographs of them and mementoes of home. Why don't foster children have large, framed pictures of their parents in their rooms? Many have snapshots, but why shouldn't the parents have a place of honor on the child's dresser?

Mementoes of home would also help the child. I wonder why, when we are preparing a child for placement, we don't suggest that he take some favorite object along that will always remind him of home. The picture and the memento could then be mentioned casually from time to time.

Foster parents should be helped to see that casual conversation with the child about his parents is desirable. If the little girl's pretty hair is just like mother's, why not say so, just as the foster mother might remark that her own daughter looks more and more like grandma? Why couldn't we say casually to a child that daddy has a birthday next month? Let's see, how old would he be now? It is through such discussions about the details of family life, through the jokes about grandfather's mustache cup, through comments about whom one resembles, through remembrances of birthdays, that we come to have a sense of belonging. Through such little things do we feel that we have roots in the past. There is a place for some of this in the life of a child in foster care. By these devices foster parents keep open the subject of the child's own parents.

Of course, we shall have a difficult time getting foster parents to do these things. However, let's not forget that foster homes are to serve children, and the support and guidance we give foster parents must always be in that direction.

The third thing a social worker can do to help the child with his relationship to his parents lies in the realm of work with the parents. Admittedly the steps suggested here require careful, time-consuming work. Good child placement is neither easy nor cheap, and one is often led to wonder if as good results could not have been achieved if an equal amount of thought, effort, and time went into working with the child's parents before placement was considered.

When it seems as if placement of the child is necessary, whether because of circumstances beyond the parent's control, or because the parent desires it, or because the parent really cannot cope with the responsibility of keeping the child, we must help this father or mother to play a modified role in the child's life. The manner in which he or she adapts to this new role will be influenced by the kind of treatment received from the social worker and the agency she represents.

Sometimes after a parent has ceased to visit the child and has therefore lost contact with him, it seems as if this may have happened because no one ever made the parent feel important. Defeated as a parent, faced by this defeat at every visit to the foster home and at every request not to bring so much candy, not to stay so long, not to upset the child to such an extent, many a parent finally gives up.

Only when we recognize why the parent brings too much candy and stays too long, only when we catch some insight into a father's or mother's life, and feelings, and needs, only when we feel with and for this person as a human being, apart from being a parent, can we help him see that he has not wholly given up responsibility for the child.

Children need to have parents visit. Anna Freud points out that we have been wrong even in asking parents to wait for a few weeks until the child seems to be settled in foster care. It is better for the child to have the parent visit soon after placement, even though these visits seem to increase the child's homesickness and grief. And visiting is not the only way parents can help in a child's adjustment; some children are helped by knowing that the parent is paying for the care.

There is one implied but final conclusion in all this. The more we recognize the importance of the parent in the life of the placed child, and the more we come to know and to like the parent, and the more we come to respect him or her as a human being, the less often shall we place a child too hastily and without making every effort to preserve for him his own niche in this universe, which is simply his place in his own home.

"Neuvola" or Well-Baby Clinic Protects Health of Finnish Children

SAMUEL KRAKOW, *Regional Supervisor, Scandinavian Operations, American Red Cross*

FINLAND works to protect the health of its children through "neuvolas," or well-baby clinics. The neuvola not only serves as the place to examine children and their mothers, but also operates as the focal center of public-health programs for the community.

The first large neuvola was established in 1922 in Helsinki by the Mannerheim League, which is the child-welfare branch of the Finnish Red Cross. Since then the league has been encouraging all the communities in Finland to build or equip neuvolas and has been giving practical assistance in getting them started. So successful has this effort been that most of Finland's 500 communities now have some kind of neuvola, and in accordance with the new public-health law every community will be required to put one into operation within the next 2 years.

Quarters of neuvolas vary

Obviously, since each community assumes the responsibility in setting up a neuvola, there is considerable variation in the physical arrangements. The finest is the one at Malmi, in south-central Finland, which is endowed by the Rockefeller Foundation. At the other extreme are the neuvolas in some of the poorer communities, especially in those damaged by the war, where the housing situation is particularly acute. In one village I found that the public-health nurse had rented one room; it was partitioned in the middle by a sheet hung on a string; one section was the neuvola; the other was the nurse's living quarters.

There is also a wide variation in equipment: the better ones have ultraviolet lamps, good examination tables and scales, pleasant waiting rooms, and so forth. Others have nothing more than a paper-covered straw mattress on a crude examination table. Many are without scales. (To meet this shortage the American Red Cross has sent 200 baby scales to Finland.)

However, the purpose of the neuvola is everywhere the same, namely, to safeguard child health. The presence of a public-health nurse, who is in charge of the neuvola, is the result of the Mannerheim League's work. (The league also worked to bring about the new public-health law, which will require each community to provide a nurse for each 4,000 of the population.)

The neuvola has regular examination days, generally several times a week; the doctor comes once or twice a month, also on schedule. Mothers are encouraged to bring their babies every week soon after birth but later a visit every 2 or 3 weeks is considered sufficient.

You can tell when it is clinic day at the neuvola. In the summertime you will see a lineup of small, low, wooden carriages with wooden wheels. In the winter, you will see these same carriages, equipped with wooden runners; and many of the little "kick sleds" one finds everywhere in Finland. (The kick sled is merely a little chair mounted on long metal runners. The baby is tied securely to the seat; and the mother holds on to the back of the chair, stands behind on one of the runners, and pushes or kicks backward on the snow or ice with her free foot.)

Inside the neuvola there is the usual noise found in baby clinics.

Some neuvolas provide little baskets or boxes for the babies' clothing; less elaborate places provide nothing more than chairs on which clothing can be piled.

Undressing a baby for examination is a complicated business, since, to put it mildly, the babies are bundled up well to protect them from the cold. A wrap called a bunting is very popular; it is roomy, and square in shape except for a rounded hood; nothing of the baby is visible except his face.

First the baby's record card is taken out of the files and then the baby is weighed and measured and examined, by the nurse, or on certain days, by the doctor. The nurse recommends changes in diet, gives advice on various problems, answers an anxious mother's many questions, and also gives out leaflets on various aspects of child care. In addition, the nurse distributes vitamin preparations, cod-liver oil, baby powder, powdered milk, and so forth. Immunizations of various kinds are given, and if the parents wish, their children may receive the BCG vaccine, which helps to provide immunity against tuberculosis.

This public-health nurse, on the staff of one of Finland's neuvolas, or well-baby clinics, is setting out to visit babies whose families live far from the center of the community.

In order to make some of the neuvola services available to people who live far from the center of the community, the nurse takes periodic trips to the country. On these trips she often carries with her a portable scale. In the summer she travels on foot or on a bicycle; in winter by horse and sleigh if they can be had, but more likely on skis or by kick sled.

Then there are "mobile neuvolas," each of which consists of a team, including a doctor and a nurse, and a midwife if there is one available. These teams visit remote areas, where few if any medical facilities are available. In pleasant weather the clinic's work is done in the open; in bad weather the team uses whatever facilities the local Mannerheim League chapter has available, often the home of the nurse or teacher. The mobile neuvolas give the same services as the

(*Continued on page 30*)

Ship Carries Health Services to Coastal Villages of Alaska

Scattered along a coast line longer than that of continental United States, the people of many villages in Alaska have little or no medical service at hand. And so the Alaska Department of Health, with the cooperation of several Federal agencies, sends a ship, the *Hygiene,* along part of the coast, carrying a doctor, a nurse, a dentist, and a laboratory technician. Equipment includes a doctor's and a dentist's office, an X-ray room, and a small laboratory. And there is a waiting room and a record room.

The *Hygiene* travels to as many villages as time and weather permit, beginning with southeastern Alaska. The department of health hopes to extend the service until every village is visited at least once a year. At present it is estimated that 20,000 persons are reached in a year, including whites, Indians, Aleuts, and Eskimos.

Among the most important of the health services provided on the *Hygiene* are the services for mothers and children, some of which are shown here.

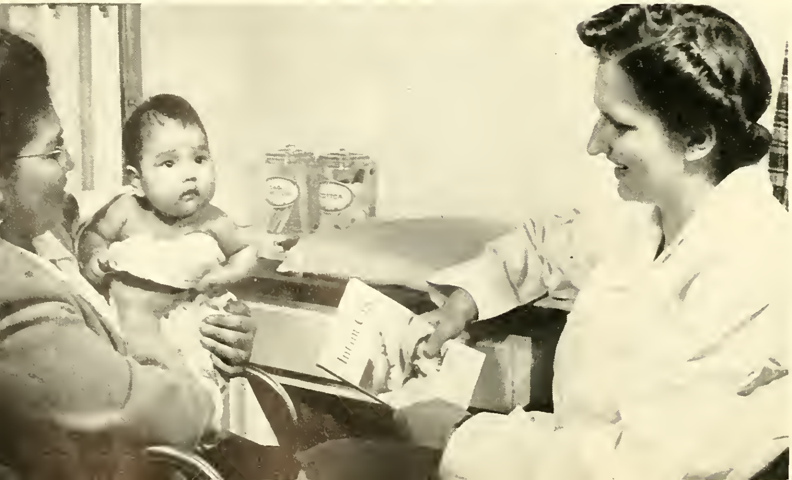
This boy lives on an Alaska island where there is no dentist. The "Hygiene's" dentist is going to treat his teeth. But first he is gaining the boy's interest by showing him how the dental instruments work.

FOOD C
FOR GOOD DENTAL
Brush your teeth twice daily
Visit your dentist twice yearly

Here are some of the children of a remote Alaska village, coming on board the "Hygiene" for medical and dental examination and treatment. People of all ages are given these services on the ship.

A public-health nurse on the "Hygiene" is weighing an expectant mother before the doctor examines her. Weighing at regular intervals is an essential in prenatal care.

Examination of the baby's ears with the doctor's otoscope will not hurt him. But he doesn't quite like the idea, even with mother holding him quite safely in her arms.



After examining the baby, the "Hygiene's" doctor is giving his mother instructions on how to take care of him so as to keep him well. A copy of *Infant Care* should help.

School-age children are examined by the doctor aboard the "Hygiene." The little girl's mother sits beside her as the doctor listens to her lungs and heart with the stethoscope.

Immunization against diphtheria and other diseases is an important part of the doctor's work on the "Hygiene." Each immunization is noted as part of the child's health record.

FOOD AND CARE
FOR GOOD DENTAL HEALTH

With the help of a poster, the doctor is demonstrating the proper use of a toothbrush. She also tells the children about various kinds of food in relation to dental health.

rom the Start

A mothers' class in nutrition, held on the "Hygiene" by the public-health nurse, is discussing the subject of milk and its value in a mother's diet before and after a baby's birth.

Showing the mother the X-ray film of her little girl's chest, the "Hygiene's" doctor says it is possible that the child has tuberculosis, a common disease among native Alaskans.

Physically handicapped children, as well as other children, get medical attention on the "Hygiene." This little girl has tuberculosis of the hip and the doctor is examining her.

HOMEMAKER SERVICE HELPS TO PRESERVE FAMILY LIFE

FRANCES PRESTON, *Home Economist*
RIKA MACLENNAN, *Supervisor of Homemaker Service, Family Service Association of Cleveland*

CHILDREN thrive best in their own homes, and on that axiom homemaker service is based. Its usefulness has increased as social workers have learned how to help parents use he service advantageously.

Homemaker service as one part of case work is an answer to parents who ask how they can keep their homes functioning in spite of the temporary—or even permanent—incapacity or absence of the mother.

Short-time homemaker service, given during a temporary absence of the mother from the home, is known as "interim care." Long-time service, given during extended or permanent absence of the mother, is known as "inclusive care."

Both short-time and long-time care given by homemakers afford children the security of their own homes and the continued companionship of at least one parent. As the children grow they can develop with their father normal parent-child relationships, and with their brothers and sisters they can learn the give-and-take natural to children of the same family.

Much depends on father

A case worker uses homemaker service, of course, only when the family wants to maintain the home, and when one parent at least has a strong enough personality to make a constructive plan possible. This does not mean, however, that homemaker service should be considered only when a father is a stable, adequate person. On the contrary, the service is of value even when he is a passive and dependent person. His passivity, if not extreme, may be an asset, helping him take the role of mother for part of the time. The father for whom such care is most likely to succeed is the one with warmth of feeling for his children, and understanding of them. He needs enough stability to take more responsibility than he would carry if the mother were in the home, and he must be willing to cooperate with both the homemaker and the case worker. It is essential that the father retain his position as head of the household.

Short-time service

Placement of the children because the mother is in a hospital or ill at home may be a traumatic experience for them. When the mother is having a new baby, for example, the children may be farmed out among neighbors or may be left at home uncared for unless the father stays with them. A homemaker, taking over the care of the children in their own home, enables the father to continue working and relieves his anxiety and the mother's about the home, thus facilitating her recovery. Many fathers try to arrange for this service themselves but find they cannot afford to pay what a competent person would charge.

Children are likely to suffer from fears aroused by their mother's illness and her absence from the home. If they stay in their own home these fears can be dealt with more easily and fears of the unknown are not so likely to arise. Tensions are lessened, so that the whole family has a better chance of returning to normal living after the mother's convalescence.

In this way the sense of security of the C family was maintained. Mr. C came to the agency several months before his wife's confinement, asking for help in planning to prevent a repetition of previous difficulties. He said that the family could not again stand what happened when his wife was in the hospital for the birth of the youngest child. Then they had placed the children away from home. Worry over them had sent Mrs. C into a nervous collapse that kept her in the hospital for several weeks and piled up doctor and hospital bills. The children later came home upset and fearful about what might happen next. The family took months to get back to ordinary life.

The case worker found physical conditions in the home poor but she also found close family ties and a fair amount of stability on the part of the parents, particularly the father. While the case worker was making plans to provide a homemaker she was able to help Mrs. C to some extent in getting over her insecurity and anxiety.

During Mrs. C's convalescence at home, the homemaker gave her some of the mothering she needed. She also helped Mrs. C to build up her feeling of adequacy by praising her good care of the children and by helping her plan her work more efficiently and by letting her know that her attitudes toward her children helped them to be happy and well-behaved.

The C's were enabled to maintain their family unity during a time that they had feared might bring a family break-down. As a result the parents are better able to meet future crises.

Children need own home

Both short-time and long-time services are based on the same principles. The aim of long-time care is to give the children the opportunity to live in their own home with their own family. Parental warmth in their own home offers children the best opportunity of learning to become consciously aware of other people, to form patterns of independence and cooperation, and to develop self-confidence. The homemaker supplements the father's efforts to provide the right conditions for his children's physical, mental, and emotional development.

Case workers need a high degree of sensitivity and of professional skill to use homemaker service constructively in long-time care. Thorough evaluation and diagnosis are as necessary as in any other form of case work. Whether or not the family really wishes this kind of service should be determined during the exploration of all possible plans. The case worker must understand each member of the family in order to get a complete picture of the situation. She

Condensed from paper given at National Conference of Social Work, San Francisco, April 13–19.

must know their characteristics, the role played by each parent, and the place of each child in the family in order to select a suitable homemaker and to help her fit into the home. Much more detail about the way of living is needed than is usually obtained in case work. In order to supervise the homemaker the case worker must know about household management and equipment, low-cost food planning, and economical buying of clothing. Detailed discussion of finances with the parents is necessary to determine the amount the agency must contribute toward the homemaker's wages and toward buying needed household equipment.

The case worker will find herself in new, many-sided relations with the homemaker and with members of the family. Utmost skill is sometimes needed to keep a proper balance in these contacts.

The case worker will guide the homemaker while she is adjusting herself to the family, and often will help her in understanding problems caused by the absence of the mother and other problems more deeply rooted. The case worker may need to work directly with the father or some other member of the family as well as with the situation as a whole. At the same time she may be working on environmental and health problems, giving supportive help, and treating emotional problems. The case worker may give these same services in other family situations, but here she has that extra factor to consider—the homemaker.

As an example of the ramifications and complexities of the family situations that homemakers try to meet, let us look at the long-time care of the X children.

Mrs. X deserted her husband and four children when the responsibility for their care became too much for her. Deprived of love as a child, Mrs. X had a great need for material things, perhaps because they represented the love she lacked in childhood. Mr. X was crushed by his wife's desertion. He blamed himself because he had not given her the things she wanted. He had chosen, for example to keep a night job with moderate wages, that was secure rather than change to a temporary day job that paid more and would have satisfied his wife while it lasted.

After Mrs. X left, the children were cared for temporarily by an elderly relative. Then Mr. X sought the help of a social agency because he could not solve the problem alone. He was determined to keep the children together, yet knew he could not afford to hire a person competent to take care of them.

Study by the case worker disclosed a strong feeling of confidence between father and children. The father showed willingness to cooperate with the agency, and a homemaker was placed in the home. The father's characteristic passivity made it easy for him to take, without complaint, full responsibility for the children during week ends and to cooperate with the homemaker. Yet his masculinity was sufficiently dominant to be of basic value to the boys.

With the help of a homemaker, this family is making out well while the mother is in the hospital. Father cooks breakfast, and the homemaker arrives before he leaves for work.

The homemaker, a warm, motherly person, yet capable of firm control, has now been in the home for 3 years. During the first months she needed a great deal of supportive help from the case worker, and praise for her efforts, for there were many problems. She was handicapped even in her housework, for the mother had taken with her many necessary pieces of household equipment.

The two older children, Bill, 8, and Paul, 6, were quiet, docile, well-mannered children, who at first gave the homemaker little concern. But the two younger ones, Joe and Ann, did. Two-year-old Ann would cry herself to sleep at night, would wet the bed, and would wake up screaming for her mother. After about 2 months she gave up crying and screaming, and in less than 6 months she no longer wet the bed. She began to accept the homemaker and she improved in every way.

Joe, 4, presented a different picture. His aggressive behavior, resistance to control, refusal of food, and unresponsiveness naturally caused concern to his father and the homemaker. The case worker spent much time helping the homemaker to win the boy's confidence. Finally he began to improve, though he is still sensitive and easily hurt. He occasionally has temper tantrums, but he has developed a gratifying responsiveness.

Though Bill and Paul were no trouble, the homemaker gradually realized that they were too quiet and withdrawn from other people. With the case worker's help, both the homemaker and the father worked toward building up the boys' self-confidence and their interest in play and in other children.

The experience of being deserted by their mother will leave a scar on these children. However, the feeling of security that a strong family unity gives would have been lost had it been necessary to place the children away from their home or had the father tried to ke care of them alone. The father ept a real home for his children; surely he community must consider this a ound investment of time and money.

Homemaker service is often of value ven if the prognosis for success is poor, s with the family of Mr. and Mrs. A. Irs. A, mentally ill, is in a hospital ermanently. Mr. A, even though he as a regular job, is never out of debt. n fact, having debts seems to be as ompulsive to him as drink to an alco-olic. He has some warmth of feeling or the children—Agnes, Jim, and Pat, ut feels that he must express it by giv-ng material evidence of his love—thus ncreasing his debts.

The oldest child, Agnes, 8 years of ge, was an extremely unresponsive hild, whose slight security seemed ooted in her attachment to her father. She met most questions with silence or 'I'll have to ask my father." Jim, 5 ears old, was likable, but was infantile n his behavior. He wet the bed, talked aby talk, and tried excessively to get ttention. Both he and Agnes had eat-ng difficulties. Pat, the baby, though f normal size for his age, 8 months, was so retarded in development that he seemed subnormal. Usually he lay in his baby buggy, making no attempt to sit up or even turn over.

The outlook was discouraging, but the father did show industry at work, had good personal habits, and firmly desired to keep the children with him. A trial period of keeping the children at home was decided upon: it has lasted a year and a half and is to be continued.

The first homemaker could not get along with Agnes. Jim and Pat, however, responded well to her care and began to improve. Because Agnes continued to be unresponsive, an additional case worker worked with her for 8 months.

When a more friendly type of homemaker became available she was placed in the home to replace the homemaker who was baffled by Agnes. The second homemaker accepted the child as she was, extended quiet friendliness, yet exercised firm control. With the help of the case worker she slowly achieved a relation of mutual confidence with Agnes, probably the best the little girl had had since her mother rejected her at the time of Jim's birth—the real cause of Agnes' difficulties.

After a while, Agnes changed. She lost her tense, scared expression. She is still afraid of new acquaintances, but with people she knows she laughs and talks in a spontaneous way. She is over her eating difficulties. She takes some part in school activities and has several playmates. This progress in getting together with people has been sufficient to show that Agnes is not psychotic, as she once seemed.

It probably would have been disastrous for Agnes to be placed in a foster-family home, for separation from her father might have intensified her difficulties. Placement in an institution, where she might have had less personal attention, would probably have caused more repression.

Meanwhile Jim was progressing, too, no longer reverting to his infantile habits. And at the insistence of the case worker, the father allowed Pat to be taken out of the baby buggy and placed in a play pen where he could move about. His progress was slow at first, but in 6 months he made up for the time lost in early babyhood.

Homemaker service a success

Though there is room for further progress in this family, the three children have a much better chance to grow into well-adjusted persons than they would have had without the care of a homemaker. Their father has shown the least change of all, but he has always cooperated with the homemaker, shows pride in the children's progress (and claims credit for it). He gets satisfaction from being the head of the household. Under the guidance of the case worker both of the homemakers respected his position, included him in all planning, and let him retain all the responsibility that he could handle.

These histories will be labeled as success stories. They are, but they are typical of many histories of homemaker service. Some of this service is not successful, and, of course, other services are more suitable for some families. Some families will not accept the guidance of a case worker; others lack the stability to hold together. Children from such homes may do better in the controlled environment of an institution than at home without their mother. Careful evaluation through case work is necessary to determine the best plan for each family.

When these boys' mother went to a tuberculosis sanitarium their father thought he would have to place them in a foster home. A homemaker made foster care unnecessary.

One situation is extremely difficult—that of the chronically ill mother at home. In short-time care the presence of the mother in the home is seldom a difficulty, but in long-time care there is danger that the mother may feel displaced. Because of her insecurity she may have mixed feelings toward the homemaker, regardless of the homemaker's suitability and skill. The mother is likely to overprotect the children or to fear that her husband will lose interest in her. She may let her dependency develop so far that she cannot bear to give up her illness, or she may find a new one. An example will show the actual difficulties and the lack of success.

Mrs. M, mother of five children ranging in age from 2 to 15 years, returned home after hospital treatment. Relatives who had cared for the children while she was in the hospital could not continue to do so during her long convalescence. An experienced homemaker was placed in the home.

Mrs. M resisted suggestions that the children help with the housework; she treated the homemaker like a maid. The mother and the homemaker disagreed about discipline and the responsibility for it. Mrs. M was critical of the homemaker's work, was overexacting, and gave directions in a dictatorial way. She accused the homemaker of not caring about the children, yet she resented any attention the homemaker gave them. After 4 months of this confusion, the homemaker refused to continue.

Before another homemaker was placed in the home the case worker discussed with Mrs. M the plan of work. Mrs. M acknowledged that she had been overexacting and unreasonable and agreed to new arrangements, which included a work schedule for the older children. In spite of this, when the new homemaker came the mother continued to expect an impossible amount of work and refused to let the children do part of the housework. After this second trial of 4 months, the case worker decided to take the second homemaker out of the home because both mother and homemaker were dissatisfied. The mother then decided that she could assume full responsibility for the children if she could have part-time help with the heavy work. This arrangement, too, lasted for only a few months because Mrs. M demanded so much attention.

The constant friction between Mrs. M and the homemakers about the care of the children was not good for them. And without a homemaker the three older children learned to do things for themselves and for the family. The mother did not change much. Although her health improved, she continued to get considerable gratification from her invalidism.

Background of the service

Homemaker service is not new. A few social agencies have had it in their programs for almost 25 years.

The U. S. Children's Bureau, recognizing this service as a method of child care, called a conference on it November 1937 in Washington. The conference considered the principles of organization, satisfactory standards of service, and means for guiding the development of the service along sound lines. Participating were representatives of national and local agencies in the fields of social work, public-health nursing, home economics, and vocational training.

The next year, 1938, the National Committee on Homemaker Service was formed. This committee has continued under the guidance of the U. S. Children's Bureau and with the active participation of the Family Service Association of America and the Child Welfare League of America. The committee and the Children's Bureau jointly have made possible distribution of descriptive material to social agencies that are interested in starting the service. Recently the Bureau has published "Homemaker Service: a method of child care," by Maud Morlock (Pub. 296, 1946).

Directory to be issued

The Bureau in cooperation with the National Committee on Homemaker Service is now planning to issue a directory of agencies that offer such service as part of their regular casework service. There are probably between 50 and 60 of these agencies, in both the family and the children's fields, including a few public agencies in large cities.

The Russell Sage Foundation, at the request of the committee, is compiling the monthly statistics reported by 31 agencies in order to encourage development of uniform statistical methods and to provide sound information on which to analyze and evaluate the progress of this type of child care.

In the course of the growth of homemaker programs, many people have asked if such programs are an integral part of case-work service. It is, according to Mary Richmond's definition of case work, quoted by Gordon Hamilton in "Theory and Practice of Social Case Work": "Social case work may be defined as the art of doing different things for and with different people, by cooperating with them to achieve at one and the same time, their own and society's betterment."

Reprints available in about 5 weeks

Finnish Well-Baby Clinic

(Continued from page 22)

fixed neuvolas. In 1946 about 20,000 children were served by mobile neuvolas.

In the 25 years since the neuvolas began their work, they have made significant advances in improving the health of children. In Helsinki, at the time the neuvola started operations, infant mortality was estimated at 15 percent; now it is less than 2 percent. The activity of the neuvola has greatly reduced the incidence of rickets, a disease still encountered with alarming frequency in Finland, where during the long winter season there is so little sun. (In one particularly poor area deep in northeastern Finland, the village doctor told me that all the children in his area had rickets, including his son.)

Although the health work for children has been delayed by the war, every effort is now being made to make up for lost time. Owing to severe shortages of many much-needed baby foods and other preparations, many countries and organizations, including the American Red Cross, have sent considerable amounts of supplies, which have been distributed through the neuvolas to Finnish children. These supplies, plus the heroic efforts of the Finnish nurses, and the great interest of both the public and the Government in child health have helped materially to safeguard the health of the Finnish children, who are the future of Finland.

Reprints available in about 5 weeks

• CALENDAR

Aug. 27–29—National Association for Nursery Education. San Francisco.

Sept. 8–12—Third American Congress on Obstetrics and Gynecology. St. Louis.

Sept. 11–13—U. S. National Commission for UNESCO. Chicago.

Sept. 22–25—American Hospital Association. Forty-ninth annual convention. St. Louis.

Oct. 6–10—American Public Health Association. Seventy-fifth annual meeting. Atlantic City.

• IN THE NEWS

For Youth Conservation In South Carolina

South Carolina's Youth Conservation Committee, which was appointed by Governor R. J. Williams in October 1945, made substantial progress during its year of fact-finding studies in the fields of services to children and youth—health and medical care, education, child-welfare services, recreation, child labor, and religion—to be used as a basis of recommendations for the "development of adequate resources and facilities for the sound growth of all children in our State." In addition, its subcommittee on legislative survey has been analyzing the existing State laws affecting children and preparing recommendations for a future legislative program.

Two meetings were held, in May and October 1946, for progress reports of the subcommittees on their study and recommendations, and for coordination of plans for the next steps.

In February 1947, soon after Governor J. C. Thurmond took office, the committee strongly recommended to him that in order to carry out effectively the work begun by its subcommittees on study of the conditions and needs of the children of the State and on coordinating and advising youth-serving programs, both State and local, the Youth Conservation Committee should be put on a permanent basis, with an appropriation. Also, the committee recommended that a professional executive should be employed to direct the work of the committee and to work with local committees to be organized in each county.

Governor Thurmond, recognizing that the recommendations had merit, asked that the report be presented to the committee on reorganization of State government, to be appointed by the general assembly.

Awaiting the reorganization, the Youth Conservation Committee voted in March to return its functions to the State Federation of Women's Clubs, which had originated the youth conservation movement in the State.

After its annual convention in April, the federation invited the State P. T. A. and the State conference of social work to join with them in forming a State citizens' committee on children and youth.

Twenty-three State-wide organizations have been asked to join in the work of this committee, "to coordinate the activities of the many State-wide child-welfare committees and to plan a program that will be helpful to organizations serving the needs of children."

The planning board of the former Youth Conservation Committee, composed of representatives of 12 State departments or agencies serving youth, has been asked to continue as an advisory body for the citizens' committee on children and youth. The organization was completed at a meeting of representatives of the 23 organizations and the advisory board on June 12 in Columbia.

Stella Scurlock

Labor Information Bulletin Revivified

Readers of *The Child* who are especially interested in child labor and youth employment will find in the *Labor Information Bulletin* more detailed information in that field than *The Child* usually has space to publish.

The *Labor Information Bulletin*, enlarged and revivified now that wartime restrictions have been removed, is issued monthly by the United States Department of Labor to give news about the Department's plans, programs, and projects, including child-labor and youth-employment programs.

Sample copies of the June and July issues of the *Bulletin* have been sent to all readers of *The Child*.

States May Now Use Federal Grants For Temporary Boarding Care For Children

Federal funds under title V, part 3, of the Social Security Act as amended (Child Welfare Services) may now be used to pay for temporary boarding care for special groups of children.

An amendment to the regulations for administration of the act, effective June 11, 1947, has been issued by the Acting Commissioner for Social Security. This amendment enables State public welfare agencies to develop, under State plans approved by the Children's Bureau, such services and facilities as (1) subsidized boarding homes for temporary care of children needing shelter, detention, or emergency care, (2) temporary foster-family care of nonresident children, and (3) care of some unmarried mothers and their babies when other facilities are lacking. Previously boarding home care could be paid for from Federal funds only under certain emergency conditions.

Now that the regulations permit the use of Federal funds to pay for temporary care of children in foster-family homes a number of the States are including in their plans for the fiscal year 1948 special projects for temporary care of children in foster-family homes.

The need for services and facilities for temporary boarding care, particularly in rural areas, had been expressed by State public welfare administrators at the four regional conferences on child welfare called by the Children's Bureau in the fall of 1946.

According to the Federal Register for June 11, 1947, "the last sentence of section 203.6 of the regulations relating to Child-Welfare Services (42 CFR, Cum. Supp., 206.6) is amended to read as follows: 'A State shall not expend such funds to pay for the cost of care of children in boarding homes or institutions which provide care for children except, subject to appropriate conditions specified in the State plan, with respect to temporary care in boarding homes or projects for care in such homes for special groups of children to meet particular needs.' "

British Film Available

"Children on Trial," a motion picture showing the British program for combating juvenile delinquency, is being made available in the United States by the British Information Services, 30 Rockefeller Plaza, New York 20, N. Y.

Our thanks for the August cover go to Tony and his puppy, and to Esther Bubley, who caught them with her camera for the U. S. Children's Bureau.

Other credits:

Page 18, Library of Congress photograph by OWI.

Page 19, National Youth Administration photograph.

Page 21, photograph by Philip Bonn, for U. S. Office of Education.

Page 22, photograph by American Red Cross.

Pages 23–26, photographs by J. Malcolm Greany for the Alaska Department of Health.

Page 28, photograph by Wesley Mason for the *Hartford Courant*, used by courtesy of Family Service Society, Hartford, Conn.

Page 29, Federal Public Housing Authority photograph.

CHILDREN'S BUREAU HAS THIRTY-FIFTH ANNIVERSARY

Thirty-five years ago—in 1912—Congress passed a law creating the Children's Bureau and requiring this Bureau to "investigate and report . . . upon all matters pertaining to the welfare of children and child life among all classes of our people."

In August 1912 the Bureau opened its doors. Since then the public has become increasingly aware of the needs of children and has supported measures to meet them.

The movement for greater effort to understand and fulfill children's needs had begun before the end of the nineteenth century, and the founding of the Children's Bureau was a step forward. This movement has continued ever since, in spite of rough going and occasional set-backs, toward the goal of a fair opportunity for every child. And the Children's Bureau has been a national center for these efforts.

In the three and a half decades since 1912, saving the lives of many mothers and children has been perhaps the most important gain.

In 1912 no one knew what our infant death rate was, for few States kept good enough records of births and deaths to enable the Bureau of the Census to calculate the rate.

After State recording of births and deaths improved, we found that the death rates for both babies and mothers were very high.

Thousands of deaths of mothers and babies are now prevented each year, largely through advances in medical knowledge, better sanitation, refrigeration of food, better water and milk supplies, rising standards of living, and better public understanding of what saves the lives of mothers and babies.

The Federal Government is now cooperating with every State in the Union, as well as Alaska, Hawaii, Puerto Rico, the District of Columbia, and the Virgin Islands, in providing health services for mothers and children and medical services for crippled children.

As public opinion has led to better child-labor and school-attendance laws, boys and girls are getting more schooling and are being better protected from exploitation. But the conditions of employment for boys and girls who do go to work are better than the children had who went to work 35 years ago. The working day is generally 8 hours or less instead of 10 hours or more. More restrictions have been placed on night work and dangerous work. It is true that many States still let a 14-year-old leave school and go to work, but 35 years ago many States let 12-year-olds work. In 1938 a Federal act set a 16-year minimum for employment by establishments producing goods shipped in interstate commerce and 18 for particularly hazardous occupations.

In 1912 the usual way of caring for a needy child was to place him in an institution. Only one State was giving aid to children in their own homes. Now every State gives such aid, all but one with the help of Federal funds.

For children who have no homes, or whose homes are inadequate, public and private agencies have extended and improved foster care.

In rural areas and areas of special need the Federal Government is cooperating with State and local agencies in providing social services for children.

Progress has been made in understanding juvenile delinquency and dealing with it through juvenile courts, local welfare agencies, and child-guidance clinics.

States and local communities have come to have a greater feeling of responsibility for the care of unmarried mothers and their babies. This feeling is reflected in laws passed for the protection of these children, especially those placed for adoption.

From the beginning the Bureau has participated in international work for children, through the Pan-American Child Congresses; special committees of the League of Nations and the I. L. O.; the American International Institute for the Protection of Childhood; and, more recently, activities developed through the United Nations, the World Health Organization, and other international bodies, especially the International Children's Emergency Fund. Since 1942 a special unit of the Bureau has administered a program of direct cooperation with the other American Republics and has given service to specialists from all parts of the world.

We in the United States have still far to go before we can say that we are doing everything we might do to give every child a fair opportunity. But we are on our way.

Katharine F. Lenroot

KATHARINE F. LENROOT,
Chief,
U. S. Children's Bureau.

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Katharine F. Lenroot, Chief

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A BETTER CHANCE FOR NEGRO CHILDREN IN HOUSTON • Page 34

A BETTER CHANCE FOR NEGRO CHILDREN IN HOUSTON

U. S. SUPERINTENDENT OF DOCUMENTS
OCT 8 1947

MRS. H. A. WILSON *Houston, Tex.*

ALTHOUGH Negroes make up 25 percent of the population of Houston, Tex., Negro children were almost entirely left out of the community's plans for child welfare until 1939. In that year, after an extensive survey of the welfare resources of the city, the Community Chest voted an annual $10,000 for a 3-year experimental program of child-welfare services for Negro children. The program was to include case-work services for children in their own homes and also boarding-home care. To carry out this program a new temporary agency was established as a branch of the De Pelchin Faith Home and Children's Bureau, a private agency, partly supported by public funds.

A heritage of faith

De Pelchin Faith Home and Children's Bureau had been in existence nearly 50 years before 1939, but up to that time it had given services to white children only. It had been founded by Kezia De Pelchin, a woman who was so poor in this world's goods that when she died she was buried at her friends' expense. She was, however, so rich in love and in her faith "in God and in the good people of Houston" that she brought into being the first child-welfare services that the city ever had. When she died she left to the agency that bears her name an enduring heritage of courage and vision.

The new little Negro agency had no illusions about the difficulties it had to face, and it felt a real need for a big share in that heritage. Over the director's desk hung a chalk portrait of Kezia De Pelchin. Somehow her picture seemed to belong there, for to her the greatest obstacles had always been the greatest challenge.

Organization

Since the Negro Child Center was a branch of De Pelchin Faith Home and Children's Bureau, the controlling board was the board of the parent agency. The center, though, had many problems with which the parent agency had no experience, and it had a very small budget; and so an advisory committee was appointed to deal directly with the affairs of the center, the chairman of this committee being a member of the Faith Home board.

The committee consisted of equal numbers of white and Negro members. For most of the white members it was their first opportunity to meet educated Negroes, and it was their first exposure to the difficulties that confront the Negro in everyday life. If the center has achieved success, much of it has been due to the mutual respect, understanding, and confidence that developed in the two groups.

On the staff, as on the committee, both races have been represented from the beginning. It seemed, and further experience has borne this out, that wherever segregation is the accepted pattern, a certain amount of liaison work is necessary.

The center opens its doors

In June 1939 the Negro Child Center opened its doors. The office was a four-room cottage in the heart of a Negro section, but within easy reach of the parent agency. The staff of three workers consisted of a white director and a case worker and a stenographer, both Negroes. The prospect was bleak, but there was comfort in the thought that although in the past the community had shown apathy toward Negro children, yet by its very action in calling the little agency into being, it had shown that it was no longer willing that the former situation persist.

Basic conditions

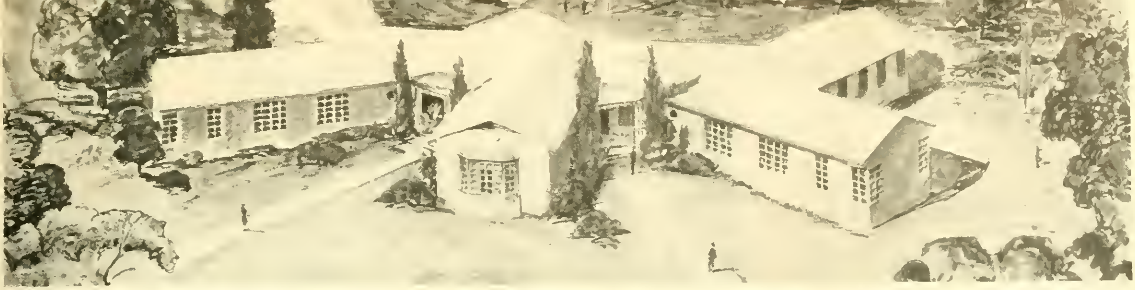
Basic conditions had to be considered in any long-range planning, conditions that were leading to a greater than normal number of family break-downs and of dependent children. (Most of these conditions still exist.)

The great majority of the Negroes were in the occupations that were least secure and lowest paid, and with few training opportunities to enable them to pass into a higher-income bracket. As with all low-income groups, economic pressure and inadequate housing were forcing families to crowd together in cramped and unsanitary quarters. In the Negro family, overcrowding, with its moral as well as its physical dangers, was accentuated, since even the higher-income group had to live in districts designated for them, with high rents and inadequate accommodations.

Many of the Negro houses had open privies. The houses were for the most part on unpaved streets, either with no drainage or with open ditches. After rains the streets were under water, which remained standing long after the rains had been forgotten.

Conditions among the children

The streets were as a rule the only playground of the Negro children. Even in families with both father and



Negro children in Houston who need temporary care will be housed in this modern cottage. It opens its doors in September 1947.

mother, the majority of the women had to work outside the home, and a great number of the children were left alone from morning to night. Older children, without supervision and with no recreational facilities, were running the streets and fast becoming delinquent. There were no day nurseries. and small children were locked up in the house all day by mothers who had no other way to manage. Deserted, widowed, or unmarried mothers. struggling to keep their babies, were forced to make what plans they could. and Negro babies were often given away with little or no planning for their future welfare.

Health

Poor health goes hand in hand with low economic status and substandard housing, and the mortality rates for our racial groups reflected this very closely. From tuberculosis the death rate was more than three times as high among the Negroes as among the white. The significance of this in connection with family break-downs needs no pointing up.

Lack of resources

The rate of illness probably paralleled the mortality figures; and yet for a population of over 100,000 Negroes in the county in which Houston is located there were only 274 hospital beds for general hospital care. For Negro patients with tuberculosis there were in the whole of the county *only 24 beds.* There was no preventorium and no hospital care for infected Negro children.

If there were few resources in the field of health, the poverty of resources in other fields was even more disturbing.

The city and county gave considerable subsidies to Faith Home for the care of young dependent white children. but for Negro children, no such subsidy was available. The county maintained schools for older white boys and girls who were dependent or in danger of becoming delinquent, and a boarding-home program, but not for the Negroes.

There was no provision—State or local—for Negro children with special health or social problems; no schools for the feeble-minded or for the epileptic; no school for delinquent Negro girls. All the State had to offer the Negro was a small orphanage, a school for delinquent boys, and limited aid for children who were deaf or blind. Apart from this and some emergency work done by the State department of public welfare, there was no provision for the Negro child.

A surprise and a challenge

Realizing the need that must have accumulated as a result of generations of neglect, the staff assumed that when the office opened there would be an avalanche of calls for help. With outward courage. but inner trepidation. they braced themselves to accept whatever might come. It was an anticlimax to find that the center was almost completely ignored. During the first few months the only requests for care came through other agencies.

A modern child-welfare program was outside the experience of the bulk of those who needed its help. The resources to help other children had for them been unobtainable. and they had had to work out their own welfare plans. Children had had to go to work early and distant relatives had learned to accept great responsibility. Organized authority frightened these people, especially authority that had relationship with court action.

This slow acceptance of new ideas is not characteristic of any racial group. Looking back into the establishment of welfare programs in other groups, we were surprised to find how much of the same defensiveness had existed in the past, and how gradual had been the development and the growth. Recollections of those early difficulties had grown hazy during the long years when we had been content to let the welfare of Negro children lag behind.

It was a shock at first to realize that the community was unable and unready to accept our desire to be helpful. Then came the feeling of challenge. It was going to take time to win confidence and prove to these families that the agency was working in the interest of Negro children. It was going to take courage and skill to turn to the best advantage the tremendous inherent strength in this close family tie and this distant-relative type of planning. The effect of these homespun methods is shown by the fact that only one of every four children who have come to the attention of the agency has had to be placed in paid foster care.

Milestones

It is in the early struggling days of an agency that the incidents occur that later stand out as milestones in the memory—milestones that measure progress as well perhaps as any statistics.

One day toward the end of the first year, a Negro sorority came with a gift of $200. It was not the last gift from the sorority nor was it the largest, but it was the first public expression of confidence on the part of a Negro organization, and it came at a period of discouragement. The staff will never forget the lift it gave to their hearts.

But our milestone par excellence was Baby Louise! Louise was our first foundling. A Negro husband and wife were sitting on the front porch when they heard a baby crying. Over by the hedge, they found a cardboard box carefully padded, and in it a little Negro girl about 7 months old. She had been well cared for and was evidently unused to being kept waiting for her supper. Beside her lay a bundle of nicely washed and ironed clothing and a nursing bottle, empty, but apparently sterilized. There was something touching about the little dresses in the bundle; the material was cheap and roughly put together, but there was a little clumsy handwork on each.

When Christmas came the face of Louise beamed a cheery greeting from the center's first Christmas card. The photographer had caught something in her expression that won its way into the hearts of all who saw it.

Ever since that Christmas, the center has used the photograph on all its stationery and publications.

We did not realize at the time that the day that Baby Louise was brought to the center was to be a turning point not only in her life, but also in the life of the struggling little agency, nor that she would come to be to many the symbol of all that the agency stood for.

A permanent agency

By the middle of the second year the Negro Child Center had begun to hit its stride. Gradually a better community acceptance of the agency's functions had come about. Better relationships had been established with the courts, with the hospitals, and with other agencies. The number of children brought for help or counsel had steadily increased. In the course of 2 years applications had been accepted for some form of service for 215 children.

It was not a bad record for a $10,000 yearly budget, but we realized that without additional funds we would not be able to hold our own in the coming year. It was decided to approach the Community Chest and to give an account of the 2 years of our stewardship and then to ask that the experiment should now be considered a permanent agency and be financed accordingly.

The Chest not only granted the 40 percent increase that we asked for, but did it so cordially that the workers returned to their planning with a greater feeling of security than they had ever had before.

Since then the Chest has never failed to give us an annual increase. It has not always been all we wished for, but it has been steady, and for this year, the seventh of the agency's existence, the budget has reached $53,000, more than five times the original one.

Kezia De Pelchin was right in her conviction that with community knowledge would come community support.

The gift of Anna Dupree

Early in 1945 the community was startled by a gift to the Negro Child Center of $20,000 to build a cottage for children like Louise. The gift came from a retired beauty operator, Mrs. Anna Dupree. It was one of the first, and certainly one of the largest gifts that had ever been given to charity by a Negro in the South. Anna was one of nine children, who had grown up in great poverty. An enterprising girl, she had learned to be a beauty operator, and had built up a thriving trade.

Soon after the Dupree gift a sorority of Negro professional women volunteered to buy the land for the cottage. Within a few months they presented a check for $2,500 to the center. When they presented this gift, they made one stipulation and that was: If when the time came to buy the land, it was found that a larger sum was needed, they should be given the *privilege* of raising the rest of the money.

It was little wonder that the faith of the Negro Child Center grew with that sort of encouragement. When the following year suitable land was found, the price was $6,000. The sorority not only made good its promise, but 6 months later presented us with $1,000 to furnish the living room.

Then requests to be allowed to furnish rooms and to supply equipment came in from other sororities and women's auxiliaries, without solicitation by the agency. There was no doubt of the tremendous interest and potential strength that existed in the Negro community.

The gift of Mrs. Dupree came at an opportune time. The program from the first had been entirely limited to foster-family home placement, and while this plan would always be the main resource for caring for the children no matter how the program might develop in other ways, yet it left the agency vulnerable in case of emergencies.

There were many foster-home resources for the white child, some 800 beds in all, but for the Negro group there were only the 35 foster homes that the center had developed. Since the war had begun, this situation had become more difficult, for many of the best Negro families had moved away, and others had given up caring for children to take jobs in the community.

Search for a site

Even though the money was assured, we knew that to find a site was a major undertaking. Not only were all the buildings in most Negro neighborhoods substandard, but so were the physical surroundings. The committee decided that it had better be clear as to what conditions were essential, and then start a real search for the land.

In the minds of the group the following seemed to stand out:

1. The land should be reasonably well-drained and should be easy of access.

2. It should be near good schools, good health facilities, and good recreational facilities.

3. It should be located in a modest, self-respecting community.

Knowing the slimness of the resources, however, we suspected that our ideas were a little Utopian, but we were all so firmly convinced of the value of the undertaking that we were quite willing to hitch our wagon to a star.

Eureka!

It was not till a year after the Dupree gift that we found what we wanted. It was a beautifully wooded area of 9½ acres in the heart of the most densely populated Negro area in Houston. The land had just been released for sale after prolonged litigation, and it far surpassed in every way our rosiest dreams.

The land was only two blocks from a main thoroughfare with good bus service; and most of the homes adjacent were owned by the occupants, stable people with long records of steady em-

Houston has replaced these slums with a public housing project. But others remain.

ployment. One of the best grade schools for Negroes was right across from the property, and a high school was in easy walking distance.

St. Elizabeth's Hospital, a beautiful modern building, was within six blocks; and Hester House, the only community house for Negroes in Houston, was also in the neighborhood. To crown everything, the price was within our reach. Almost breathlessly we put down our money. We felt as if the whole world must be waiting to pounce on our promised land!

There was an additional 4½ acres adjoining our property; and last year Hester House bought it. The possibilities for service that may lie in these 14 acres are limitless.

Now that we had the land, we asked our architect to draw up plans for a receiving cottage for about 20 children.

Before these plans were completed a bank president gave the center $25,000 to erect a building in memory of his son. It was decided to use this money toward building an administration and community building, which would include a neighborhood health clinic. This would satisfy a crying need, for with over 300 children coming for casework or other service each year, our little office was bursting at the seams.

Almost before we knew it, the center found itself embarked on a campaign to raise a building fund of $110,000.

Looking back, it is interesting to realize that from the first it never occurred to anyone at the center that we could build any but first-class modern buildings, functional and dignified, and that we undertook what was to this group the raising of a very large amount of money as a matter of course. It is even more interesting that no one in the community has so far ever questioned the wisdom of our assumption.

The center breaks ground

In December 1945 ground was broken for our new buildings. This was the first step in launching the campaign. The agency had $45,000 to start with, and, true to the De Pelchin tradition, it had also a deep faith in God and in the good people of Houston.

Fund raising

Of course, $65,000 is a large sum to collect when most of the contributions will be small. But while large gifts make matters move faster and are much easier on the nerves of those responsible for money raising, yet it may be that smaller gifts from a large number of people do more in the long run toward community good will.

And that brings us to the most appealing gift of all. A heavy express package arrived at the center. In it was $26.36, all in nickels and pennies, and with it was a card in straggling childish characters: "Lov from Baby Louise." It was hard to believe that our little patron saint was growing up, and there was real inspiration in her loyalty and in the fact that she and her adopted parents were still following the fortunes of the Negro Child Center with eager and affectionate interest.

At present the amount collected stands at $104,000. The Negro group has contributed most of this, but the contribution of the white group is not far behind.

The old order changeth

It is now 7 years since the Negro Child Center opened, and during those years more than 1,154 children have passed through its doors. This summer the agency is moving into its new $118,000 plant.

In this development there is no doubt that the real motive power has always come from within the agency itself.

But motive power cannot function without a framework, and in this case the framework was established when the community itself demanded that Negro children be included in the planning. Every time the Chest has increased the budget, that framework has been strengthened.

Other influences also have been at work. While the agency has been developing, a world war has been fought, and with the calling to service of all groups and with the names of people of all races in the casualty lists, there has come about an inevitable modification of community attitudes. Our talk of "one world" has brought with it the natural corollary of "one community," and we are coming to realize that what happens to any one group vitally affects all groups.

With this realization, new dignity and new hope have come to the Negro people, and with increased economic security there has come for them the opportunity to put into effect some of their ambitions for the children of their race. Their cooperation in the work of the center is only one indication of their resolutions.

The old order has been changing, yielding place to a new one, and we are ready, as we have never been before, to think of service in terms of *every* child.

It is very doubtful if there is in the country any community which cannot, in the next few years, equal or surpass the record of the Negro Child Center, if it approaches the task with courage and patience, and with infinite and imaginative faith.

Reprints available in about 5 weeks

CHILDREN OF DIVORCE

WILLIAM D. COCHRAN,

Formerly Circuit Judge, Nineteenth Judicial District of Kentucky

CHILDREN OF DIVORCE are stepchildren of our courts. The laws and the court procedures for handling the problem of children of divorced parents are much the same as they were several generations ago, and it would appear that, at least in our courts, the problem is not recognized at all.

Years ago, when the procedures concerning divorce and child custody were developing, divorces were infrequent; and children of divorce, though individual problems, were not the social problem that they are today, since there were few of them. However, divorces are no longer infrequent, and children of divorce constitute a considerable proportion of American youth. In the light of this change in our social complexion it is of real importance that we reexamine legal procedures to the end that our courts may more intelligently and effectively handle the problem.

If the problem is to be intelligently met it must be first faced squarely as more of a social problem than a legal one.

At present the court sets up a new situation for the child or children of parents involved in a divorce action. Whether the new situation has any relation to the real interests of the child, and whether it leaves as few emotional scars on his personality as is reasonably possible under the circumstances, is something else.

How about interests of child?

Serving the welfare of children, just like intelligent adjudication of any problem, depends upon how well our courts are informed before the judgment is rendered, and intelligent information is something that our courts simply do not get. The child is unrepresented, save by the harassed judge or chancellor himself; there are no competent witnesses to advise the court about the child's interests. This statement will not be received graciously by most parents and a few lawyers but it is nevertheless true.

Neither courts nor lawyers have the special education and training that would enable them to determine intelligently what action in a given case will serve the real interests of the children involved. This may also seem to be a broad statement. However, no lawyer or court need feel offended, for child welfare is a highly specialized social science. It is an independent field of endeavor, about which lawyers and courts know little or nothing and are not expected to. If we are to get reliable information as to what these things are all about, it must come from those who, by reason of education, training, and experience, should know.

The picture of lawyers swapping the interests of children over their desks and reporting to the court in all seriousness that the parties have reached an agreement would be actually amusing were not the situation so deeply serious and the results to children so pathetic. All it means is that opposing parents, through counsel, have reached an understanding, at least partially satisfactory to each. This relieves the chancellor of the necessity of making an independent guess and then worrying over the outcome. If nothing appears radically wrong to his uninformed mind the "understanding" of parents and counsel is placed in the judgment and the typical child of divorce is on his way. If legal opinions of the past are to be criteria of what we can expect in the future, the child of divorce will be no better off as time goes on.

Parents, and their testimony of charge and countercharge, do nothing more than confuse the issue of the welfare of the children, and counsel on neither side are of any assistance. As lawyers, they do not necessarily understand underlying emotional problems of a child who is confronted with a broken home, and also, they often become so determined to fulfill the desires of their clients that the real interests of the child get little or no place in the picture. Irrespective of how conscientious a chancellor may be, and certainly all our chancellors try to be most conscientious, he is nevertheless lost, and it is the child, of course, who suffers.

As heretofore suggested, if this problem is to be met with any degree of real success it must be first recognized as the social problem that it is. It cannot be solved by the application of any known set of legal rules or maxims, and the longer we delay in taking a more intelligent and objective approach the more serious the situation will become. Certainly it is serious enough as it is, for at present some 80 to 90 percent of all litigation in our circuit courts involves problems in domestic relations.

Tug-of-war between parents

About the only rule our courts have developed that has the unqualified approval of child psychiatrists is that, generally speaking, little children are better off with their mothers. However, so far as the law is concerned, the application of this principle is most often so cluttered with rights of visitation that it becomes of little or no value, and so the child continues to be the center of a tug of war between parents. Save in cases few and far between, the most a court ever gets from the record is the feud between the parents, and many records consist of nothing more than invective. Under such circumstances, and it is the standard situation, no court can be expected to be able to act in the real interests of children.

During the war we learned that a sizable proportion of our young men were unfit to fight because of emotional immaturity and instability. Information concerning the number of these boys who had been children of divorce might be of more than passing interest.

Let us look at some of the things that contribute to a child's normal development as compared with what happens in our courts.

A personality that is mature and able to adjust to normal social existence in a productive occupation is just as important to an individual as his intelligence. But for the children under discussion the opportunity of normal personality development in a normal home

Condensed from an article by Judge Cochran in the Kentucky State Bar Journal, September 1947.

is not theirs. The application of legal rules generally makes this impossible. The real question is: What will come closest to giving the child the environment that his parents, by reason of their refusal or inability to get along together, are taking away from him?

Instead of answering this question, our courts are often called upon to decide as between father and mother whether the pot or the kettle is black and to enter a judgment for the welfare of the child accordingly. The right answer for the child can be reached only through objective investigation, not through the application of set rules or some compromise whereby each parent gets a part of what both selfishly want.

About the only rule that our courts have developed that has the unqualified approval of child psychiatrists is that, generally speaking, little children are better off with their mothers.

First in the normal, natural development of a child is a sense of security, the feeling of belonging some place. The child who is the center of a dispute between parents seldom has this, and if he has it, our courts may unwittingly take it away from him.

The opinions of our courts concerning custody are full of statements that the welfare of the child is foremost, that children are not chattels, and so forth. But it seems that we then proceed to take care of the personal desires of the parents.

No sense of security

Court orders, instead of permitting the children to grow up normally, call for 3 weeks with one parent and 1 week with the other; the school months with mother and the summer months with father, or vice versa. Six months with one parent and 6 months with the other is not at all unusual. During his entire childhood the child of divorce becomes the subject of a struggle between parents for his affections. Under such circumstances, we have nothing but a legalized method of promoting abnormal emotional development. The poor kids never get the chance to develop any sense of security and they belong no place at all.

In the next place, even though parents are at odds, the real interests of the child suffer when the natural sense of respect and admiration for either parent is impaired. The parents themselves contribute to this before the matter ever gets into the hands of lawyers. Instead of keeping the children as far from the battle as possible, the parents permit them and often encourage them to enter into it. In many instances, they are present during the taking of evidence and quite often, under the influence of one of the parents, a child himself testifies. If the child is over a given age, though so young in development as to have no mature judgment, the court is supposed to listen to his expressed wish, though the place that he wants to stay may be merely the place where he is assured of the most luxuries and the least discipline.

In many cases, after being subjected to the tirades of each parent, the child gets the idea of not belonging any place at all, thinks that neither parent wants him, or is fit to have him, and develops a sense of loneliness that will be a handicap to his normal emotional development and a plague to his entire adult existence. Sometimes he is shoved into some school where the authorities have no knowledge of his background, and before long they find that he is a runaway.

Another thing is that children need to feel that a single authority exists to which they are subject. Where we have divided custody, rights of visitation, and so forth, the child not only does not have this feeling, but cannot get it. In many instances each parent, when with the child, not only attempts to alienate him from the other but curries favor with the child so that he will want to come back again. The child is in the middle, and if this is the best that can be done for him, the chances are that he might be better off without either parent.

These are but three of the many principles, violation of which prevents the child of divorce from growing into a normal, well-adjusted adult. They illustrate how we are abusing the children of divorce instead of helping them. If the child of divorce is to be like other children, we must not permit him to be placed in abnormal situations if we can possibly avoid it. Of course, we do not violate the interests of children purposely. Lawyers and courts simply know no better and cannot be expected to know without the assistance of the kind of special and technical advice that is indispensable if an intelligent conclusion is to be reached.

Court needs technical advice

Lawyers differ in opinions of legal matters, and doctors differ in the diagnosis and treatment of illness. Nevertheless, an intelligent man in trouble does not go to the barber shop for his legal advice, and a sick man who wants to get well does not go to a witch doctor. Why then should we continue to give only lip service to child welfare, about which we, as lawyers, know nothing, and permit our courts to enter orders affecting the entire future of children without any proper advice on the subject whatsoever?

Many a lawyer feels that he has fulfilled his professional obligations if he acts as if he were the parent he represents, and it is the service of such members of the profession that sometimes seem most in demand. Voluminous and expensive records are developed which cannot possibly serve the real interests of any child and which never give the court any intelligent guidance.

Our court of appeals has commented on this on several occasions, and in a recent case, in permitting a mother to take her children to another State for permanent residence, gave as justification for this the elimination of the stench with which the divorce action had been surrounded. However little our courts may know of child welfare, and they can be expected to know but little, they know, and properly, that these performances do not and cannot serve the real interests of a child.

An honest and intelligent approach to the problem is for the legislature to prescribe a procedure that will make it possible for courts to obtain special service and advice.

In our cities it is becoming more and more common for informed and socially responsible lawyers to send parents to competent child psychiatrists. In this manner an intelligent and expert disinterested opinion for the benefit of the child is obtained. A reputable doctor of psychiatry renders professional service for the sole benefit of the child.

If a decision on custody is ultimately necessary, the court can have the benefit of sound advice from a competent source before acting, since the doctor, having made an objective approach and being competent in his special field, makes an able witness for the child. Expert assistance of this sort may sometimes lead to the discovery of the real reason why parents are unable to get along together. The cause may occasionally be eliminated, and reconciliation accomplished. Children are always better off with both parents if they have a contented, responsible home, and any other arrangement, even such as is made upon the basis of the most expert advice, is, at best, nothing more than a substitute.

In these days, expert advice is becoming more and more difficult to get. The impetus given psychiatry by the war has made it virtually impossible to get into the office of a first-class practitioner—for they are all too few—short of an appointment made many weeks in advance.

According to information given the State Judicial Council of Kentucky some of our circuit judges are having investigations made by child-welfare workers where such workers are available. This is believed to be a sound practice, and during the writer's service as circuit judge he did likewise.

Quite often a court feels that he is making Solomon's choice, and few realize the tremendous responsibility of the circuit judge who in making a single decision may well affect the entire life of a child. For example, what is one to do in the following instance?

Rightly or wrongly, the custody of a child of very tender years whose parents were divorced had been awarded to the father. The mother was married when very young, had had no real girlhood, and had been unhappy with her husband. The pattern is familiar. The husband later boarded the child with a childless couple. Subsequently the mother remarried and was happily adjusted, her new husband was willing and anxious to assume the obligations of a father toward the child, and the matter was reopened. The father had also remarried, and the couple who had the child were desirous of keeping him. All were financially able to assume the responsibility, and there was no moral question involved to cloud the issue.

How is it possible for anyone to believe that a court can act intelligently in such a situation without some sort of special advice? Even experts do not welcome this kind of problem, yet the entire future of a bright little boy may hang on how successfully the problem is met. Such a problem, involving a boy 5 years of age, was presented in the Mason Circuit Court in 1945. Not only is this not a legal problem; it is a problem that lawyers cannot even argue intelligently. The court in this instance, who happened to be the author, did not hesitate to take the problem at his own expense to the best child psychiatrist he could find. Whatever the result of such a case, even if it was handled exactly right, it should have no value as a legal precedent. The answer in the next case may be entirely different, and so legal precedence as such is of little or no value.

It is terrifying enough to make decisions in these matters even when fortified with the most expert advice available, but when we realize that our cir-

Children of divorced parents now constitute a significant proportion of American youth.

cuit courts are, for lack of any other way, feeling their way around in the dark, it makes one wonder how long we are to continue grinding out children of divorce by the hundreds, children who may be headed for early delinquency and, perhaps, doomed to be handicapped and emotionally unstable in adulthood.

This is the situation. We can do but one of two things. Either we must shut our eyes and let nature take its course or we must attempt to meet the situation as intelligently as we can. We cannot have psychiatrists to advise all our courts. In no more than a handful of communities is there available this kind of special advice, and, though meeting the problem adequately requires the application of this specialized branch of medical and social science, there is no practical way to obtain it except in a few cases.

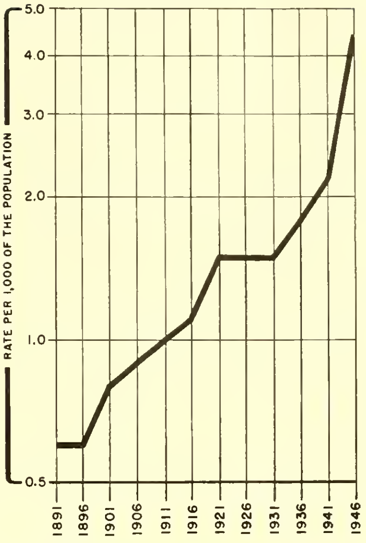
Some have suggested that the court appoint a guardian ad litem (to act for the child in the case). This is an excellent idea, since it gives to the child his natural social right, independent representation at court. However, no matter how good the guardian ad litem may be, he needs competent advice if he is to represent his client or clients capably. The only kind of advice that can be of real value to the child and the court is that based on information obtained through an objective investigation by a competent person trained in the delicate social science of child welfare.

Job for child-welfare division

The child-welfare division of the department of welfare of my State has been criticized because of the delay in handling cases. These delays are due to the severe shortage of trained child-welfare workers, a situation which should be remedied gradually as trained personnel become more available. Since many children of broken homes end up as delinquents and ultimately become the reponsibility of the child-welfare division anyhow, it seems reasonable to believe that many delinquencies might be avoided if the agency could enter the picture in its early stages before the child's problem becomes acute.

It is believed by many, and certainly it is reasonable belief,, that no court order which in any way affects a child should be entered without an objective investigation by a person trained in child welfare. Certainly this is the least we should provide.

DIVORCE IN THE UNITED STATES
1891 TO 1946



* Estimate

Source: FEDERAL SECURITY AGENCY
U. S. Public Health Service
National Office of Vital Statistics

When a child is to be adopted, the law of Kentucky makes the department of welfare a necessary party to the adoption proceedings. The reason for this legislation, of course, is to assure the child of as good a home and as good an opportunity to develop normally as is possible under the circumstances.

The same reason exists in custody procedures in divorce cases even though the other parties involved happen to be the parents.

What is best for the children?

After parents separate, a child will have new adjustments to make and it is most important that they be made successfully. This cannot be achieved through "show cause" orders, producing children in open court, and so forth. The results of objective investigations should be a part of the case record, and the opinion of the child-welfare worker should be prima facie evidence of what is best for the children involved.

Anyone with any experience with parents at war with each other knows that often an effort to obtain custody of a child is merely a matter of spite to keep the other parent from getting anything. People want their friends and the public to know that they won. They want everyone to feel that whatever the trouble might have been it was the other party's fault.

When a court has a record such as suggested, he can act intelligently in the interests of the children. Otherwise he can do nothing more than grope in the dark, wishing that he had some sort of Divine help; and, because he hasn't, he often creates more problems than he solves.

Since these problems are of social character and are problems of social welfare, they demand a new approach. A person trained in child welfare can be of invaluable aid in assisting the parent, or other person who may have the custody of the child, so that he can more easily adjust to the new environment.

Furthermore, once an order is made it should not be forgotten by the court. The child-welfare worker should maintain adequate contact with the case and be ready to recommend to the court such changes as may be required in the interests of the child. A guardian ad litem to represent the children, fortified by a witness who is educated and trained to know at least some of the answers to the delicate problems involved should enable our courts to act in a far more intelligent manner.

It is by no means implied that these ideas offer a ready cure for the bad situation described. As long as there are divorces and children of divorce the problem will always be with us. However, if the challenge of a bad situation, so close to the legal profession, is to be intelligently met, the circumstances must be faced as they are, not as we should like them to be. To meet the challenge with any degree of success, methods must be applied which give some promise of actually solving the problem. It is common knowledge that it has not been successfully met heretofore, and certainly it deserves unselfish, objective thinking. The end to be attained for the ever-growing number of our children of divorce is worth far more than whatever effort is involved.

Reprints available in about 5 weeks

# SOUTHWEST LOOKS AT PEDIATRIC NURSING

Now that wartime pressures are off, both hospital and public-health nurses are taking stock of their work and are making extra efforts to improve it. Various State health departments, recognizing the nurses' desire to keep up with the most recent developments in their field, have been offering them opportunities for further education. Examples of such efforts are found in the recent institutes, or conferences, on pediatric nursing that were held in the spring of 1947 in Arkansas, Louisiana, Oklahoma, and Texas. These were sponsored jointly by the State departments of health, State universities, and State crippled children's services, in cooperation with nursing organizations and other agencies. Assistance in planning was given by the U. S. Children's Bureau regional nursing consultant for the Southwest.

An account of each of these pediatric-nursing conferences, written in the State concerned, is given here.

LOUISIANA

LILLIAN JEFFERS

Maternal and Child-Health Consultant Nurse
Louisiana State Department of Health

Public-health nursing and institutional nursing were equally represented at the pediatric-nursing conference held May 26–30, 1947, at New Orleans, under the sponsorship of the Division of Maternal and Child Health of Louisiana's State Department of Health and the Department of Nursing Education of the Louisiana State University School of Medicine.

The conference was led by Dr. Milton J. E. Senn, New York Hospital and Cornell University, and Mrs. Margaret Adams, R. N., Columbia University.

Some discussions were led by Dr. Henry Barnett, Cornell University; Dr. James Q. Haralambie, Cornell University and New York Hospital; and Dr. Myron E. Wegman, Louisiana State University School of Medicine.

Mrs. Adams told the conference that to work constructively with children, a nurse must first try to understand herself and to find out whether or not she really likes children. A nurse who does not like children cannot pretend. Children understand from the way the nurse talks or touches them whether her attitude is sympathetic.

Lack of time and pressure of work are frequently given as the reason for omitting the little kindnesses that children need in order to feel secure, said Mrs. Adams. But, she added, it does not take any extra time to call a child by his given name or to greet him and tell him good-bye. When a nurse takes a child to the operating room no extra time is necessary to introduce him to the nurse in that room and to tell him that she, his ward nurse, will be waiting for him when he returns to his room. After a painful treatment given to a very young child, the nurse, with no loss of time, may cuddle him in her arms to comfort him, perhaps while talking with the physician about the treatment. No extra time is necessary for the nurse to hold an infant in her arms, instead of her lap, while feeding him.

Discussing premature infants, Dr. Barnett said that although only about 1 out of every 20 newborn infants is premature, practically half of all neonatal deaths are attributable to prematurity.

Measures to combat the high death rate for premature infants must be taken during pregnancy, to prolong the period of gestation, said Dr. Barnett, and also during delivery and the postpartum period.

The essentials of good care of premature infants, whether in the home or in the hospital, are based on extensive clinical experience and knowledge of certain physiological handicaps of premature infants, Dr. Barnett went on. Such care must include provisions for control of body temperature; prevention of infections; skilled medical and nursing supervision; proper feeding; preparedness for immediate emergencies; and preparation of the family for discharge of the infant from the hospital and follow-up in the home.

Dr. Senn reminded the conference that pediatrics is sometimes called a specialty dealing with diseases of children, but, he said, this is too narrow a definition. The pediatrician is interested in diseases, but he considers sickness an incident in the life of a child; more important is the child's health. And most of the time the pediatrician is dealing with a child who is well.

The pediatrician must have an understanding of the well child before he can treat the sick child, Dr. Senn went on. He must know the child's parents, his brothers and sisters, and others in the family; the family environment; and people outside the family in the immediate community.

Dr. Senn pointed out that anyone who deals with children—the physician, the nurse, the jurist, the social worker, the teacher—is confronted with a mass of problems that seem insoluble. Delinquency, broken homes, increased divorce rates, and so forth, are of concern not only to social workers and the clergy, but also to physicians and nurses.

We must understand, said Dr. Senn, that growth and development is a process that is going on constantly from conception to death. Age should not be a barrier to growth and development, and parents should grow and develop while rearing their children. The kind of parents a child has plays an important part in determining what kind of an individual that child will be, said Dr. Senn.

The regular pattern of growth and development is not a straight line, Dr. Senn continued. There are periods when the child seems to stand still or to go backward. He seems to be holding on to the past. He knows what he has, but is afraid of the future. After this seeming standstill, the child may go rapidly ahead.

Although growth and development proceed irregularly, there is an interrelationship between the physical, emotional, social, and intellectual spheres, according to Dr. Senn. That the nurse should have a philosophy for her approach to child care and behavior is more important than just getting necessary information regarding it.

Dr. Senn pointed out that to obtain maximum development of an individual's potentiality, we must begin with gestation. Thus the antepartum experiences of the mother are important. The mother whose diet is inadequate may have a damaged offspring. A communicable disease, especially German measles, occurring early in pregnancy may injure the fetus.

Emotional development must also be considered during the antepartum period, said Dr. Senn. The mother has certain feelings about her pregnancy, about the baby who will be born. Mother and father both have questions. Prospective parents need opportunity to talk over with the doctor what is on their minds.

Examination of the mother during the antepartum period should be more than a physical examination, Dr. Senn went on. She should be given time to ask questions. Every question, even if it seems foolish, should be answered. The doctor should identify himself with the patient and look at her questions through her eyes.

The time to consider infant feeding, Dr. Senn told the conference, is in the antepartum period. Changes in the mother's breasts cause her to think about whether or not she should breastfeed her baby. The doctor should talk with the mother about what breastfeeding is, how to do it, and its advantages.

Just as soon as possible after the birth of the baby, give the baby to the mother, said Dr. Senn. The physical contact of holding her own child gives her the feeling that she is a mother. Give her the opportunity to examine her baby. Let her count his fingers and toes. Give the baby to her for feeding as early as possible. The feeling that the mother has of "giving the baby of myself" (breast being self) can't be emphasized too much.

Caring for the baby must be gratifying to mother and child, Dr. Senn maintained. The baby eats not only to take in food but also to suck. He wants to do a lot of sucking, and to use his mouth for a long time. If a self-demand feeding system is used with a baby from the beginning, he will put himself on schedule by the fourth to the sixth week.

When we try to keep a young infant on a clock schedule, we are imposing on him something he perhaps does not want at the time and we might thus bring about a feeding problem in the baby early in the newborn period.

Every child in his normal growth and development has certain periods that are focal points in his life, went on Dr. Senn. These are, in general, the antepartum period; birth; the newborn period; weaning from the breast and bottle; the time when solid food is begun; toilet training; the arrival of a new baby in the family; and the beginning of school.

What is crucial in the development of a human being, in the opinion of Dr. Senn, is that he be accepted by his family, be loved by his parents, be a part of the family unit. Physical care is important, but emotional development more so.

ARKANSAS

LOUISE JAMES

Maternal and Child-Health Consultant Nurse
Arkansas State Board of Health

Interest in the whole field of pediatrics has been greatly stimulated in Arkansas by the recent State-wide survey made by the American Academy of Pediatrics.

Arkansas, a rural State, with more than 600,000 children under 15 years of age (1940 census) has only 1,396 physicians, of whom only 9 are pediatricians; 3 of these are members of the Academy.

The only children's hospital in the State is in Little Rock. Few hospitals have beds for Negro children, although Negroes comprise about one-fourth of the State's total population. Overcrowding in hospitals is general. Nurses are scarce, and most hospitals with pediatric departments are forced to place in responsible positions nurses who have had no preparation beyond basic training as a nurse.

Feeling the need for a program of pediatric-nursing education, the State Board of Health planned an institute on pediatric nursing and held it the first week in March 1947, in cooperation with the Crippled Children's Division of the State Department of Public Welfare, the State Nurses' Association, and the State League of Nursing Education. Dr. Francis F. Schwentker and Helen Schnetzer, both of Johns Hopkins Hospital, were guest speakers.

Eligibility to attend was restricted to graduate nurses employed as instructors in schools of nursing; those engaged in pediatric nursing, either in hospitals or on private duty; and public-health nurses especially engaged in maternal and child-health services, such as well-child conferences, school programs, and bedside nursing.

Some of the topics on the program were: Nutritional problems in Arkansas; medical problems in nutrition; feeding the infant and child; infectious diseases; the practical care of the infectious patient; respiratory diseases; abdominal diseases; rheumatic fever and nursing problems in this and other long illnesses; endocrine disorders and the psychological problems of the endocrine patient; congenital anomalies; and accidents.

Throughout the entire conference the leaders pointed out the importance of care for all children as an integral part of community services. Both emphasized the rights of children to a happy family life and the importance of recognizing their personal needs, whether the child is sick or well.

Films and slides were used effectively. Demonstration materials included incubators and other equipment for the

A nurse should try to understand herself and find out whether she really likes children.

cars of premature infants; books, toys, and games for various age groups; and equipment for testing the vision and hearing of school children.

Although the programs were planned for nurses, many physicians attended. So pleased were these physicians that Dr. Schwentker and Miss Schnetzer were invited to nearly every hospital in Little Rock to observe the pediatric departments, discuss their problems, and make suggestions.

OKLAHOMA

OKLAHOMA PEDIATRIC NURSING COMMITTEE

Recognizing the fact that many local nursing supervisors are unable to take postgraduate courses in educational centers because they cannot be spared from their work, the University of Oklahoma Schools of Medicine and Nursing, the Oklahoma Commission for Crippled Children, and the Oklahoma State Department of Health jointly held a pediatric-nursing institute at Oklahoma City in June 1947.

The theme of the institute, "Helping the Nurse to Understand the Child," was developed by the discussion leaders, Dr. Milton J. E. Senn and Mrs. Margaret Adams, R. N.

Planning for the institute began in January, and included formulation of questions by nurses. These questions were forwarded to the discussion leaders and formed the basis for the program.

The institute leaders stressed the importance of the parent-child, doctor-child, nurse-child, and social worker-child relationships. They pointed out that small details may have great significance to the child, and that his reactions will give the cue for guidance.

Meeting the needs of the mother in the prenatal period and helping her to recognize the importance of both physical and psychological development of her child is the beginning of an adequate child-care program, continued Dr. Senn.

Dr. Senn discussed the infant as a "reflex animal." Sucking, sleeping, and crying when uncomfortable are all reflex actions, he said, but even at this early stage of the baby's development he senses the emotions and tensions of those who care for him.

In connection with "make believe" behavior—a topic of interest to nurses, who deal with children who have been deprived of many activities—Dr. Senn pointed out that fantasy and daydreaming are a normal part of development in the small child, and that only when they are carried to extremes are they abnormal. This phase of development, as well as the tendency to lie or to steal, has a definite cause in the child, said Dr. Senn, and we can discover this cause if we will search for it.

Dr. Senn also discussed sleep habits, toilet training, speech development, and sex education, and gave the nurses suggestions to help them understand children of different ages.

Puberty is the physical aspect of a child's growth and development, said Dr. Senn, and adolescence is the psychological aspect. The adolescent feels insecure and anxious about himself. He fears being different and wants to lose his identity in a group. This is a period of conflicts with parents and other persons in authority, and an upsurge of feeling may be "contagious" and involve an entire ward of adolescents.

Dr. Senn stressed the fact that some of the child's behavior is planned, some unconscious.

Mrs. Adams led the discussion of specific nursing problems, including "Use of masks and gowns," "Formula making," "Evaluation of techniques," and "Demonstration methods."

A local guest speaker at the institute was Dr. Charles Bielstein, pediatrician, who discussed the physiological processes immediately after birth, and infant care.

Half a day of the institute was spent discussing resources within the State of Oklahoma for meeting the needs of children. Topics included a report of the recent survey of these resources sponsored by the American Academy of Pediatrics; a discussion of the facilities available for the care of premature infants in the Oklahoma Hospital for Crippled Children; an outline of the services available through the child-welfare division of the State public welfare department; the mothers' milk bank of Oklahoma; social-service functions at the university hospital; the work of public-health nurses in local communities; the services offered handicapped children by the State vocational-rehabilitation service; community facilities for good nutrition; and the program of the Oklahoma Commission for Crippled Children. Guest speakers representing these agencies discussed the ways in which their services were contributing toward meeting the needs of Oklahoma's children.

In the concluding talk of the instiute. Mrs. Adams discussed "What it neans to a nurse to work with children." She pointed out that as the nurse begins o realize that there is a reason for each ype of a child's behavior, she becomes nore kindly, develops a sense of humor, and is aware of the fact that she must know herself.

Throughout the discussion the public-health nurse and the hospital nurse were aware of the fact that their problems were similar and that understanding the child in all his aspects is an important part of nursing, both in the hospital and in his home. The work of the public-health nurse and of the hospital nurse, they felt, supplement each other and provide the continuity essential for good nursing care.

TEXAS

ALMA ROLLINS, R. N.
Assistant Director, Public-Health Nursing

MRS. ELEANOR HAWLEY, R. N.
Public-Health-Nursing Consultant, Maternal and Child Health, Texas State Department of Health

Texans have long been aware of the high infant death rate in their State. They are not at all proud of their 1945 infant mortality rate of 48.8 deaths per 1,000 live births.

Considerable study has been given to the causes of death in Texas children of all ages. It has been found that diarrhea and enteritis cause much of the infant mortality in the State, and in the older age groups, that rheumatic fever is a leading cause of death.

Factors inimical to the health of children in Texas, as in many other States, are: Low income per capita, unbalanced distribution of hospital facilities and of medical care, lack of medical and nursing specialists in pediatrics, poor basic courses in pediatrics in many medical and nursing schools, and low apportionment of funds per capita for health programs.

Texas' first postgraduate pediatric-nursing conference was held at John Sealy College of Nursing, University of Texas, Galveston, in April this year. It was made possible through the cooperative efforts of the State Health Department and the John Sealy College of Nursing.

The objectives of the conference were: 1. To provide opportunity for nurses to present problems in child care for group discussion under expert guidance of leaders in the field of pediatrics; 2. To provide opportunity for nurses to increase their knowledge regarding the needs of the child as a whole, whether the child is well or ill; 3. To provide opportunity for nurses to review and discuss new concepts and trends in pediatric care.

The conference leader was Mrs. Margaret Adams, whose contributions to nursing education are nationally known.

The nurses who had been invited were asked to submit topics for discussion, and from these topics the program was planned. It is interesting to note that institutional nurses suggested topics very similar to those suggested by nurses in public-health agencies.

Specific conditions and diseases were discussed by pediatricians; personality development and problems by a child psychiatrist. These physicians were members of the staff of the University of Texas Medical School.

Practical demonstrations of procedures in home and hospital care and teaching exhibits were prominent in the program. After the discussion of care of premature infants, a demonstration of equipment for such care was given, and hospital procedure and techniques were discussed. An improvised incubator, a carrier, clothing, and equipment—all suggested by the U. S. Children's Bureau for home use in the care of a premature infant—were shown.

Later the procedure for preparation of milk mixtures as carried on in the John Sealy Hospital was demonstrated. This was followed by a demonstration of the use of an oil can as a home sterilizer for milk mixture. The oil-can technique is widely used in Texas, especially in homes where physical equipment is limited and refrigeration not possible.

Demonstrations of isolation technique in home and hospital were given.

Toys for children of different age groups were shown, and Mrs. Adams used this exhibit as the basis for a discussion of "Play, an Integral Part of Growth and Development." She pointed out that from play and proper toys a child learns to share with others, to respect their rights and abilities. He learns emotional control and emotional expression, kindness and sympathy as essentials in good living, responsibility, creativeness, and an appreciation of fine things. She said that through play a child develops his vocabularly; his imagination; and his attitudes toward competition, toward cheating and lying, and toward use of money.

In selecting books for children, Mrs. Adams said, we should consider how a book is used by the child. For example, for the very young child, the first use of the book is to finger it and turn the pages. Later he shows interest in pictures—then in words as related to the picture.

In Mrs. Adams' discussion of growth and development she stressed the importance of study of the well child in basic, supplementary, and advanced courses in pediatric nursing. A nurse must study not only the growth and development of the child, she said, but also mental hygiene and the psychology of adjustment, and must learn to apply her knowledge. She must learn to observe, to record and interpret her observations, to share her experience with others, and to compare experiences. She must also develop an understanding of herself.

The nurse should be alert, also, Mrs. Adams continued, to the greater demands of society upon the growing child as his experiences increase and his horizons broaden, and also to the need to plan care around the individual child.

Unanimous approval by the group attending the conference emphasized the need for more such conferences to be held in the future. We feel there has been established a better rapport between nurses serving children in hospitals and those serving children in other community agencies. We also feel sure that Texas children will receive better care as a result of this group study.

Reprints available in about 5 weeks

PEDIATRICIANS FROM 63 COUNTRIES MEET AT NEW YORK

MARIAN M. CRANE, M. D.

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TO THOSE who had never before attended an international pediatric meeting, the Fifth International Congress of Pediatrics, held in New York in July 1947, was like having the medical literature suddenly come alive. Sir Leonard Parsons ceased to be a textbook and became a lively gentleman with a charming smile. Lichtenstein, Wallgren, "Toverud and Toverud," became individuals with whom to chat and exchange ideas instead of names frequently encountered in *Acta Paediatrica.* Yllpö's name still makes one think immediately of premature infants, but now we remember also his sense of humor. Fanconi and De Toni may still be inseparably united in connection with the syndrome of renal rickets that they described, but they now have personalities of their own, one as a Swiss professor, the other as an Italian one. And so with many others, from Czechoslovakia, Greece, Hungary, U. S. S. R., China, Austria, Palestine, Mexico, and the rest.

We wished for a gift of tongues to be able to talk with all of the 63 nationalities represented. Many of the speakers used English, however, and if they did not, we had only to tune in our earphones to hear a translation. More difficult was the problem of sectional meetings. How could one attend, all at one time, sections on: "Factors in Pregnancy Affecting the Child," "Preventive Pediatrics," "Bio-Immunological Procedures," "Vitamin Requirements and Avitaminoses," "Insect and Other Vectors of Disease," and "Rheumatic Fever"? At these, and at the plenary sessions, we heard reports of physiological studies, new symptom complexes, new methods of treatment. One marveled at the scientific work that has gone on in some of the war-torn countries.

There were reports of what has happened to children in some of these countries, reports that made one sick at heart but that carried a note of hope. Dr. Jonscher of Poland told of 68 percent of public-school children aged 3 to 7 years infected with tuberculosis, and no hospitals for their care. But he sees hope for the future in vaccination of newborn infants against tuberculosis with oral BCG.

Dr. R. A. McCance of Cambridge, England, reported a study of the physiology of nutritional privation in the British zone of Germany. He found the birth weight of infants to be lower than in 1937. Children who had not received supplementary rations were shorter and lighter in weight than American children. These discrepancies were larger in the older children, and the boys were consistently worse off than the girls. But the children showed an abundance of animal spirits, and if plenty returns soon their losses should be regained.

It was heartening to learn that the services for children established before the war stood Norwegian children in good stead during the occupation of their country. Parents had learned the importance of good nutrition and were prepared to follow advice as to how to meet emergency situations. Preference in food distribution was given to young children and pregnant women, and additional welfare centers were set up to help the mothers in the care of their children. The success of these measures is shown in the general good condition of the young children. On the other hand, the school children average less than normal height and weight. Interestingly, dental caries decreased in amount during the occupation but has risen again since food supplies have increased.

Most of the numerous interesting and instructive scientific exhibits at the Congress were American, but many a United States pediatrician gazed enviously at the model of the beautiful new Children's Hospital in Helsinki and marveled that it had been built during the war years.

The spirit and the misunderstandings that lead to wars seemed remote and unthinkable in this assemblage from the nations of the earth, interested only in how to protect the health of the rising generation. As one Polish pediatrician expressed it: Perhaps pediatricians are especially internationally minded because they deal with the greatest internationalist of all—the infant who has no language. And perhaps, for this reason, pediatricians should extend their field to include not only promotion of health but education for peace.

• FOR YOUR BOOKSHELF

UNTO THE LEAST OF THESE; social services for children, by Emma Octavia Lundberg. D. Appleton-Century Co., New York, 1947. 424 pp. $3.75.

Few people are as well prepared as Miss Lundberg to portray the epic of the development of child-welfare programs in the United States. It is cause for rejoicing that we now have from her sensitive and knowledgeable pen this substantial treatise on progress made and essential goals ahead in social services for children.

Following the introductory chapters on the heritage of children and what they need, the meaning and practice of social services, and the language and literature of social work, the book focuses on the colonial and early national period in our history, which gave rise to the first institution for dependent children and the beginnings of educational programs for the physically and mentally handicapped. This was the "Child Saving Era" in which the first significant steps in the treatment of juvenile delinquency were taken.

The period between 1850 and 1900, which the author designates as the years of "Personalities and Progress," was characterized by the development of foster care, the extension and strengthening of public services for children, and further provisions for the handicapped and delinquent. The "Century of Promise" saw the establishment of the Children's Bureau on the one hand and the development of local or county services on the other, increased concern for crippled children as well as the blind and deaf, and the beginning of the mental-hygiene movement.

Other chapters deal with local, State, and Federal relations; the prevention, control, and treatment of two major problems in our society, dependency and delinquency; the legal basis of social action; and major goals ahead in child care.

To all these topics Miss Lundberg brings her own sound philosophy, her rich experience, and her literary gifts. In the two chapters entitled "Pathfinders of the Middle Years" and "The Vanguard of Progress" the book reaches its peak, in the judgment of this reader. The personal sketches of 20 leaders and crusaders in the cause of children not only make fascinating reading, but are so presented as to skillfully highlight the long, slow progress of the years through the eyes and the contributions of colorful and devoted men and women. These chapters, at least, should be required reading for every student of social work in the Nation.

"Unto the Least of These" provides the reader with an excellent springboard for action. There is cause for gratitude that such substantial progress has been made—and cause for concern that we have gone no further. As a Nation we know, probably better than any other nation, what constitutes good and adequate social services for children. We have the leadership, the resources, and the kind of society essential to the development of services of the highest quality.

Apparently one major factor is lacking in the country as a whole, the conviction that the children and families of the Nation are its most precious assets. That idea—that concept—is in truth revolutionary. The honest pursuit of such a concept would bring great and basic changes in our society. The result would not be a totalitarian state—such a state destroys all that is essential to wholesome childhood—but rather a freer society than we have yet known.

Our tradition of free enterprise and rugged individualism and the educational and psychological philosophy we have developed out of that heritage have stressed the independence of children and the doctrine that no adult should do for a child that which he should do for himself. This is still a sound doctrine, but we must constantly remember that for every one thing a child or youth can do for himself, there are a dozen that society must do for him. Emma Lundberg has stated in clear and ringing words what many of those things are; and she believes we can do them, if we will.

Leonard W. Mayo, President, Child Welfare League of America.

• IN THE NEWS

Federal Child-Labor Activities Reorganized

Administration of the child-labor provisions of the Fair Labor Standards Act and the research and advisory service with regard to child labor have been transferred by the Secretary of Labor to the Wage and Hour Division from the Division of Labor Standards. The transfer was made in accordance with the Department of Labor's 1948 appropriation act, which reduced the funds for these activities and included them in the funds appropriated for the Wage and Hour Division.

The Wage and Hour Division's Field Operations Branch will enforce the child-labor provisions along with the other provisions of the Fair Labor Standards Act.

A new unit in the Division, the Child Labor Branch, with Elizabeth S. Johnson as director, is composed of personnel transferred from the former Child Labor and Youth Employment Branch of the Division of Labor Standards. This unit will collect and disseminate information on child-labor problems and trends and will conduct the research and age-certification activities related to the child-labor provisions of the act. It will also investigate occupations considered hazardous to minors, and recommend to the Secretary orders applying the 18-year minimum age under the act to occupations found to be particularly hazardous.

Beatrice McConnell, former chief of the Child Labor and Youth Employment Branch, remains in the Division of Labor Standards, as chief of the Federal-State Cooperation Branch. In this position she will be responsible for the Division's broad program of promotion of improved labor standards.

• CALENDAR

Sept. 4–10—Sixth Catholic International Union of Social Service. Lucerne, Switzerland.

Sept. 9–13—American Psychological Association. Detroit.

Sept. 22–25—American Hospital Association. St. Louis.

Oct. 6–10—American Public Health Association. Atlantic City.

Oct. 13–17—American Dietetic Association. Philadelphia.

Oct. 13–17—National Recreation Congress. New York.

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Houston's Negro Child Center finds its success in youngsters like the one on our September cover. The picture is a Library of Congress photograph by Arthur Rothstein.

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Wanted: More Child-Health and Child-Welfare Workers

Parents now realize the crisis the schools are facing because there are not enough teachers for the children, but they have yet to realize that similar shortages of personnel are holding back the health and welfare services that children need.

Although these services are expanding, with the help of increased Federal, State, and local funds, only part of our local communities are covered, and State agencies are having difficulty in finding men and women for this work.

Some day we as a people are going to see that maternal- and child-health and child-welfare services are available for all, but long before then we are going to be brought hard up against the fact that we are not training nearly enough young people to give these services.

Child-welfare workers are in short supply. Only one county in five today has a full-time child-welfare worker, paid from public funds, and usually only public agencies supply such workers outside of the larger cities.

Workers in health fields are few, while public desire for health services and medical care is increasing. Health departments are having difficulty in filling their medical positions. Many small towns and rural areas have too few doctors. There are places now open for thousands of public-health nurses. These are the groups on whom we must depend to provide health services for mothers and children.

Also we have only 400 child-guidance clinics in the whole country, and these can help only about 50,000 youngsters a year. Most of these clinics are in larger cities, though over half our children are in small towns or rural areas.

The time will come when we should no more think of doing without these basic services for children than of doing without schools.

In the meantime, what are we doing to train men and women for these important services?

Comparatively few social workers are now in training in relation to the increasing demand, though encouragement is given by State agencies through stipends for postgraduate training for personnel in public welfare programs. We need many more social workers for work with children. Yet fewer than 3,700 young people are enrolled in schools of social work, training for all phases of such work.

The medical schools last year had fewer than 6,000 graduates, and in the last decade the number per year was nearer to 5,000. In that period the population has increased by more than 13,000,000. Few graduates train for public-health work. Not enough specialists in obstetrics and pediatrics are being trained to supply our smaller towns.

At least 40,000 more nurses are needed now, and the number entering nursing schools has dropped since the war. In the public-health-nursing field, the number is 30-percent short even to provide 1 nurse for every 5,000 of the population.

Other health workers—medical-social workers, nutritionists, physical therapists—are not being trained fast enough even to meet the current need.

The comparatively low salaries that have prevailed in the health, education, and welfare fields account for some of the low recruiting. Salaries must be raised to attract able young men and women and must draw upon all groups of the population for professional workers. This country credits itself with providing all children with a chance to go to school. But there are many who would make good nurses, doctors, social workers, who cannot get the basic educational preparation nor the professional training, either because of family circumstances or because communities lack good schools.

All our children and young people, in all parts of the country and in all racial groups, and regardless of family circumstances, should have opportunity for a good secondary education.

Higher education, including professional training, should be within reach of all capable of making use of it. When we provide for this we shall have the men and women to draw upon for the services that are needed to reach all the children of this Nation.

Katharine F. Lenroot

KATHARINE F. LENROOT,
Chief, U. S. Children's Bureau.

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Katharine F. Lenroot, Chief

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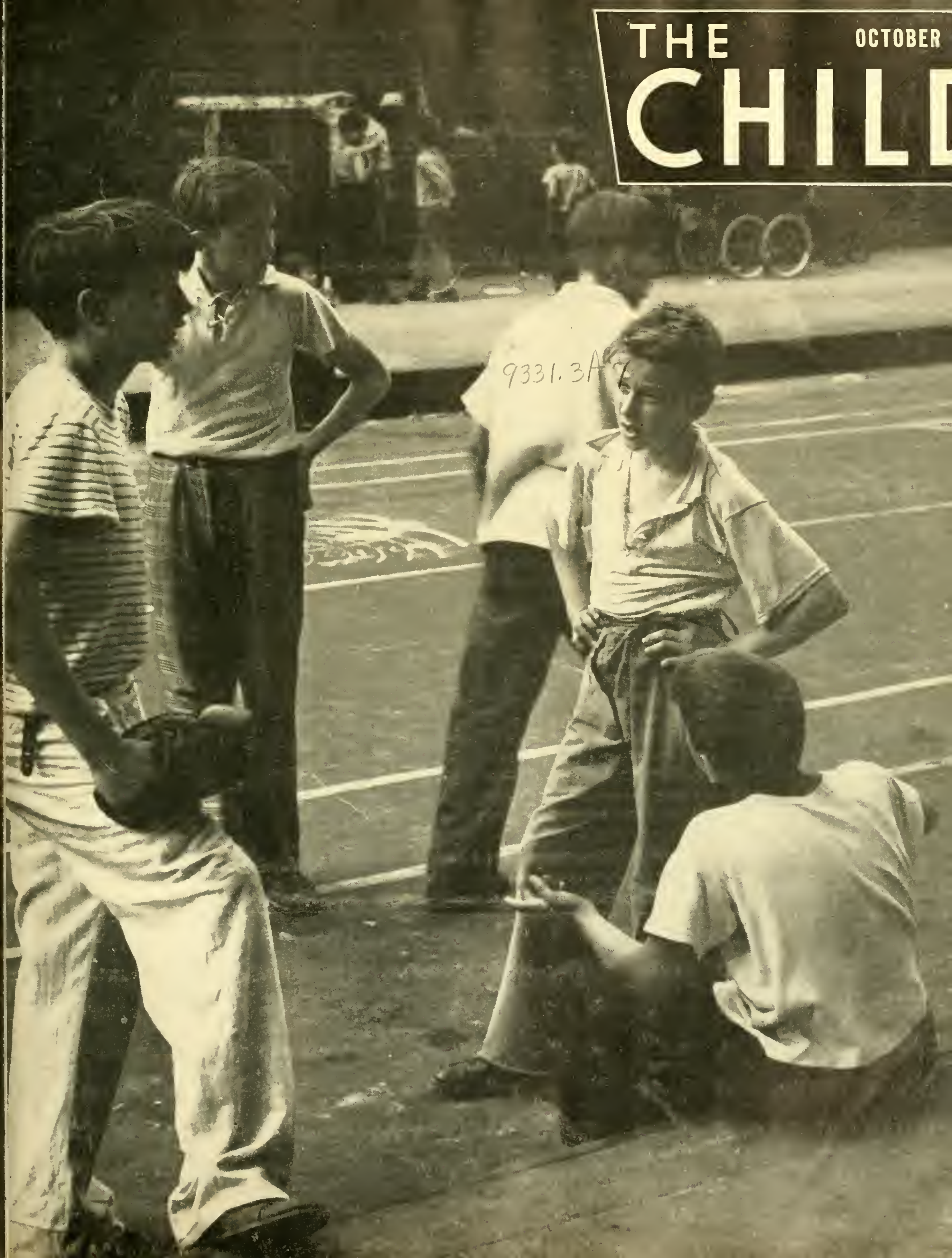

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THAT YOUTH MAY BE SERVED

British Youth Service has improved young people's opportunities for wise use of leisure time

JUANITA LUCK, *Specialist in Planning for Children and Youth, Office of the Chief, U. S. Children's Bureau*

TEEN-AGERS in Great Britain are being offered more and more opportunity for leisure-time association with others of their own age, under adult guidance. They are receiving these added opportunities through the Youth Service, a plan under which the Government helps to finance the work of the voluntary youth-serving organizations, such as the Boy Scouts and the Girl Guides, the YMCA and the YWCA, the Boys' Clubs and the Girls' Clubs, and the churches.

These organizations have been for many years offering British youngsters opportunities, not only to enjoy themselves and to develop themselves physically and mentally, but also to widen their circle of friends, to learn to get along with all kinds of people, and to become better adults, better citizens.

Recently, during a month's stay in England, I saw many boys and girls in action at the clubs and youth centers. I saw table tennis and boxing. I heard debates and informal discussions. I saw hikers and bicyclists starting out on trips. I saw a dramatic performance—a play written by the young players. These are typical activities, opportunities for which the youth-serving organizations have for many years been offering their members.

But although these organizations have always done a magnificent job (to quote a British Government report), they were able for many years to reach only a small proportion of British teen-agers.

Four-fifths of the children in Great Britain have always left school to go to work as soon as they reached the upper age limit for compulsory school attendance. And there always have been large numbers of young people who had little opportunity to get together with others, under wholesome influences.

Especially did many youngsters have little preparation for adult life through learning to manage their own affairs. At school the teacher had told them what to do; at work, the foreman or the employer did the same. And at home also many busy parents could not take the time to give their children the opportunity to learn to take responsibility.

Youngsters who belonged to the youth-serving organizations, on the other hand, came together with others of their own age, and in the give-and-take of club life many learned self-reliance.

The idea of partnership between statutory and voluntary agencies was not new; it was, and is, the usual procedure that is followed in providing educational, health, and welfare services in Great Britain. Nor was the idea of the Government's taking part in providing recreational services for youth. Nearly a quarter of a century before, during World War I, the Government made an effort to encourage local education authorities to form committees to help youth-serving organizations. But few local authorities made any real financial provision for this service, and at the time of the economic depression the service practically disappeared.

Only 3 years before the beginning of World War II, the Government had launched a national fitness campaign, under which grants were made to the youth-serving organizations by the National Fitness Council, mainly for physical education.

All this time many of the local education authorities carried on night schools or evening institutes. But these were formal courses in school subjects. They were given in school buildings. Large numbers of boys and girls attended, and profited by, these courses. But it seemed that many young people who had left school tried to stay as far away as possible from anything resembling a school.

The year 1939 brought war. Home life was disrupted; many fathers were absent, serving in the armed forces; many mothers were working in essential industries. Too many youngsters found home unattractive, to say the least. And since there was "nowhere to go but out," out they went, into the darkened streets.

Just when these boys and girls most needed a place to go, they were likely to find that the only club anywhere nearby had been bombed, and that the club leaders had left for military service. What with this loss of premises and of workers, the youth-serving organizations were having their troubles, and could serve fewer young people.

Three months after war broke out, the Ministry of Education issued its now-famous Circular 1486. This circular announced an emergency plan, under which local education authorities would join hands with the youth-serving organizations, in order to offer opportunity for social and physical development to boys and girls 14 through 19. The plan was called the Youth Service.

Under the plan the education authorities would help to pay the cost of the services, including buildings, equipment, maintenance, and so forth, as well as the salaries of teachers and leaders.

The Ministry called upon each of the local education authorities to set up a local youth committee, which would include representatives of voluntary youth-serving organizations, as well as of other groups concerned with youth, such as juvenile-employment services and public-health services, religious bodies, and representatives of industrial and civic life.

The local committee, according to the circular, was not to conduct youth activities directly; it was to strengthen the hands of local authorities and of voluntary organizations. "But coordination is not enough," the Ministry warned. "A new initiative is needed. Young people themselves must be encouraged to find, through the local youth committee, new constructive outlets for their leisure hours and for voluntary national service."

The Ministry of Education stressed in its advice to the local authorities that the content of youth services must be different from what the boys and girls experience at school or at work. It also urged that the service be planned so as to be based on the interests of the young people, and in consultation with them. The Ministry's intention is to allow individuals to choose their own type of activity, for not all persons can achieve success in all types. But all young persons, the Ministry says, may expect to find some enjoyment and satisfaction in at least exploring the various enriching elements in life, such as music, drama, arts and crafts, sports, the dance, and literature.

Under the Youth Service, the youth-serving organizations observe the following policies:

(1) The services are varied according to the interests of youth and are not uniform in character or in auspices.

(2) Each agency or organization is free to decide its own policy and to elect its own governing body.

(3) Participation of youth in the programs offered is *voluntary*.

(4) Services are not subject to governmental direction or control.

(5) Membership in each agency or organization share in the management of the agency.

And so the Youth Service began. But everybody concerned soon realized that if the local committees were to have any success in providing boys and girls with opportunities to fulfill their individual needs and to give national service in the way best suited to each, it was necessary that the committee make contact with each boy and

Club administration is [the subject of this course given by the London Federation of Boys' Clubs. In the future the boys taking the course, who are in the 16-through-18 age group, may themselves become club leaders.

girl for whom the local education authority was responsible. Therefore the Government, under the defense regulations, called for registration of all boys and girls in the country 16 through 17 years of age.

Although boys and girls who were still in full-time attendance were included among those required to register, the main purpose was to reach those who had left school and who were no longer under educational supervision.

The object was not to apply compulsion in having young people take part in the Youth Service, but rather to give advice and encouragement to them in using the time at their disposal in the ways most advantageous to themselves and to the defense of the Nation.

At the time of registration, or soon afterward, the youth committees arranged for "counseling interviews" with as many boys and girls as wished to have them. These interviews were entirely voluntary and most of the boys and girls were glad to be interviewed. Many wanted to get off their chests what they thought about the services they were getting and what they thought they should get. This free speech gave the local youth committee much first-hand information on the individual interests of the youngsters. And since the purpose of the Youth Service is to help the individual boy and girl, and not abstract and indiscriminate "youth," the committee found help that they needed in planning the services in a realistic way.

During the interviews the boys and girls were asked about their present activities, at work or school and in their after-work or after-school hours.

More than a quarter of those interviewed were living under such a pressing schedule that they could not reasonably be advised to undertake fresh voluntary activities. The committees avoided recommending further activity to young people whose obvious need was for rest. In some cases, overlong hours of work, or unsuitable working conditions, were referred to labor authorities. Likewise, when some health problems were revealed, help was sought from public health services.

Many young people were advised to join one of the defense, or preservice, organizations, such as the Sea Scouts, the Home Guard, the Girls' Training Corps, and this kind of activity proved to be popular with both boys and girls.

The interviewers discussed with the young people the various opportunities for recreation and education that existed in the neighborhoods of the young people's homes. (It was a surprise to some interviewers to find that many of the boys and girls did not even know where the public library was, nor how to enroll in it.) Many of the youngsters decided to join one of the youth organizations. Others registered at a continuation or vocational school. Some were not interested, and preferred not to join anything.

Boys and girls together eat a light evening meal at a mixed club in a pleasant atmosphere of fellowship.

The registration and the interviews gave an impetus to the Youth Service throughout the country, and much public interest was aroused in the well-being of young people, especially in the conditions of their work and in how they spent their leisure. Youth organizations of all kinds gained substantially in membership.

As one townsman said, he got to know youth in the specific, whereas he had always talked about them in general.

The Smith boy was the one who was working full time in the mill and had a year and a half before he would be called up for military service.

Mary, who liked music, was helping out in the local store part time and taking care of the younger sisters when her mother was at work. James, Henry, and Oscar, who were buddies, didn't want to work, to go to school, or to do anything, because it didn't seem important to them.

This first-hand knowledge of youth was helpful for some adults who had previously known only a few young people, usually those in a particular group in their neighborhood. It made them realize the variety of needs and interests that go along with youth. Needless to say, it both challenged and shocked some perplexed adults. As one parent said, it's a hard thing to know what the young folks want or what they can do. Many adults not only feared the effect of a changing world upon the young people but feared that young people themselves were changing. And someone asked whether the new product is not inferior to the old.

But when young people took part in adult meetings or reported from their own councils, it was sometimes a surprise to find them so good at chairmaning a meeting, so able in committee management, and so responsive in discussion.

In communities the local education authority has set up services for which they have total responsibility. These services may include a youth center, a community center, a special program of camping, a sports program, or other type of program interesting to young people.

In the years that have passed since November 1939, when the Ministry of Education issued its circular on The Service of Youth, much has been learned about young people by youth committees, youth leaders, education authorities, and everybody else concerned. Slowly, more and more clubhouses opened. More and more boys and girls began to get a chance to belong to a stable social group, to enjoy what a British report calls "the stimulus of group activity, of working and playing, arguing and laughing together; opportunity to work out their own plans and training in how to manage the affairs of their own society."

Working girls in Wolverhampton, Staffordshire, relax in their club, one of the National Association of Girls' Clubs.

If successful work with young people is to be done, competent leadership is essential. The Ministry of Education lists as desirable qualities in a leader: (1) a balanced personality; (2) personal interests outside the "youth" world; (3) appreciation of the true nature of the relationship between himself and his group; (4) tact in leadership; (5) willingness and ability to take his proper part in the life of the adult community outside his own and all other youth organizations; (6) willingness to acknowledge that a technique may become outworn and the courage to discard it when it is.

And the success and efficiency of a person who possesses these qualities would be enhanced by appropriate training, both particular and general, according to the Ministry. Training courses of themselves will not create leaders, for the essential thing is the personality of the individual; but training will always improve the quality and effectiveness of even the most naturally gifted person.

The leaders include not only full-time, paid workers, but also those that work only part time; the latter may be either paid or unpaid.

Training is given by the various youth-serving organizations in cooperation with colleges and universities. Before the war the organizations had planned a 3-year period of training, including 6 months of field work—all undergraduate. During the war, and since, 1 year of training, of which 6 months are given to field work, is the usual course.

Previous volunteer experience and work in related educational and leisure-time fields are prerequisites. The minimum age of a youth leader is agreed upon as approximately 23 years.

For mature persons, already well qualified by education and experience, a committee appointed by the Ministry recommends a 1-year course, and the Ministry is contributing funds for this purpose. For others, 3 years of combined full-time study and practice is recommended, and some universities and some youth-serving organizations are offering the 3-year course.

Part-time workers are usually trained in the evening and in week-end courses. Full-time workers usually receive their training during the last year of college. Volunteer workers, who constitute a large part of the leaders, take orientation courses, in-service training with supervision, and refresher courses.

The courses include not only such subjects as recreation, camping, and outdoor crafts, but also religious guidance, public affairs, the arts, and boy-girl relationships.

"If the Youth Service is to be a bridge by which young people pass from childhood to adult life," says a Ministry bulletin, "the bridgehead that gives access to adult ground may well be the community center." These centers serve the "young adult" group, 18 to 30. Of course, young people tend to enjoy themselves boisterously; older people more quietly. But as a step against segregating the young people from the rest of the community, the suggestion has been made that youth activities should find a place in community centers, but that in general they should be kept separate from adult activities. As the boys and girls approach the age of 18, they will naturally begin to take part in the older groups' activities and begin to be part of the adult community.

The youth-serving organizations and the education authorities know that they are still very, very far from their goal of serving every teen-ager in the country who wants to be served. Building is slow. Experienced youth leaders are scarce, and cannot be trained overnight. Postwar difficulties of every kind are in the way.

All this will require more work on the part of the voluntary organizations, with the cooperation of the education authorities in the Youth Service; how the work will develop is still in the future. But one thing is sure: British youth will be served.

HOMES FOR UNMARRIED MOTHERS DEVELOP LEISURE-TIME PROGRAMS

Prepared by the National Committee on Services to Unmarried Parents, in Cooperation with the U. S. Children's Bureau

IN the early years of the century when Mrs. Bramwell Booth, Mrs. Kate Waller Barrett, Charles N. Crittenton, and other great pioneers were working to protect unmarried mothers, the keynote of their idea was faith in the individual woman and respect for her as a person. The maternity home at that time was planned to offer unmarried mothers a place to hide from a critical public, and an opportunity for regeneration through living under moral influence.

The present-day maternity home still holds the respect for the individual personality of the unmarried mother that was so much in the thinking of the early founders of such homes, but we now recognize a greater complexity in the problem of understanding and treatment.

Modern study of human behavior has shown us that each of us reacts according to his inner needs, and that although we are aware of why we do some things, we do many things without knowing why. Often our motivations are obscure and are deeply entangled in our early emotional relationships. And psychiatrists tell us that these obscure or unconscious motivations are strong controlling elements in everyone's behavior. We therefore realize that any successful efforts to serve other persons must depend on how well we understand the meaning of their behavior.

Many unmarried mothers are adolescents, and others who are beyond that period in chronological age may still be adolescent emotionally. Thus understanding of adolescence is of crucial importance to workers in maternity homes. During early puberty, adolescence, and on into maturity, bodily changes are taking place which will accentuate any girl's emotional and social problems. Even the ordinary young girl is caught in conflicting impulses—the desire to remain a child and the desire to be an adult, emancipated from the family. Companionship with boys and men takes on new meaning. For the girl who has experienced a relatively smooth and normal emotional and sexual development, pregnancy can become the final step to maturity. She accepts herself as an adult willing to face the responsibility for her child.

Unfortunately this is not so with many an unmarried mother. She may have felt rejected and unwanted by her parents. She may have been deprived of her parents' love. Or her parents may have been overprotective and have aroused anxieties and tensions in the girl. In adolescence feelings of loneliness, of anxiety, of hostility can intensify sexual urges. Affection and acceptance that the girl should have had in her own family have to be sought outside the home. Because these girls have not had wholesome family relationships they are often misfits with their companions. They can't get along with people. Many cling to childhood and long for the parental protection that they have never experienced. Anxiety besets them. The strain of inner fears or feelings of guilt eventually manifests itself through their behavior. That is perhaps why so many unmarried mothers are impulsive, hostile, and aggressive.

And then there is to be a baby. He hasn't been planned for. He doesn't represent a step in the growth of the mother toward sexual maturity. Nor has she accepted responsibility for him. Is it any wonder that so often when a girl enters a maternity home she is far from serene?

Often she is belligerent, and critical of everybody and everything. Or she may be so cowed that she doesn't dare to assert herself. She may be passive, withdrawn, and fearful of making any plans or decisions for herself.

Thus the unmarried mother enters the maternity home with her own pattern of behavior and emotional needs. If we accept the philosophy that each girl can be served only through an understanding of her individual needs, how then can we translate this into practical principles that will guide us in our day-to-day work in maternity homes? What are the implications of this philosophy for the administration of the maternity-home program as a whole?

The maternity home is in a unique and strategic position to give the unmarried mother an opportunity to develop positive and meaningful relationships with other people. It represents an experience in group living, the success of which depends upon the attitudes and philosophy of all involved. The cook, the doctor, the nurse, the social worker, as well as the board members who formulate policies, play significant roles in the adjustment of the unmarried mother in the maternity home.

A philosophy of service must pervade all aspects of administration of the maternity-home program. Let us illustrate this briefly. Many homes have recognized the need for professional case-work services to the unmarried mother. Through her relationship with the case worker, the mother may be able to develop greater strength and capacity for making decisions. Or with the help of a skilled and understanding worker, she may be able for the first time in her life to face the hostile, resentful feelings she has toward her own parents—feelings which have played a powerful role in her own behavior.

Is the administration of the maternity home geared to a concept of service based upon individual needs? If so, then what opportunities and freedom can be offered the girl to use her emerging capacity and maturity for making decisions and planning for herself? Will the maternity home and all the members of its staff accept and live with the girl who is aggressive, domineering, and rude? Perhaps for the first time in her life, the girl feels enough security and acceptance to dare to act out such impulses. Will the staff recognize this as a long-delayed step in her growth toward maturity and emancipation from parental authority?

Condensed from paper read at the National Conference of Social Work, San Francisco, April 1947, by Mrs. Lois Parsons, chairman, National Committee on Services to Unmarried Parents.

How are maternity homes helping unmarried mothers to enjoy a fuller life through creative experience in a group? What can they offer the unmarried mother that will strengthen her capacities and prepare her for participating in the life of her own family group and of her own community?

A study is undertaken

In an effort to explore these questions, the National Committee on Services to Unmarried Parents sought information on group work in maternity homes throughout the United States. In beginning this study the committee recognized that both group work and case work—that is, social work with groups and with individuals—have the same purpose, to help people live fuller lives. And the ideal way is to provide this help through a specially trained worker.

Both the case worker and the group worker are interested in helping the individual girl.

In recent years there has been a growing recognition of the advantages of group work for persons living in institutions. Unfortunately, few maternity homes have been able to employ their own group leaders. But, despite this, many maternity homes have made the beginnings of constructive, planned programs.

In November 1946 questionnaires were circulated to 184 maternity homes, covering details of the program and asking about the philosophy and attitude of the home toward planned group-work programs. Seventy-five maternity homes, broadly representative of all sections of the United States, responded. The obvious care and thought that went into these responses revealed a sincere interest in this aspect of maternity-home service. There was also a genuine recognition of the need for further clarification and exploration of this subject in relation to the whole maternity-home program.

There were approximately 1,800 unmarried mothers living in these homes. Many of these girls were extremely young: a little less than half were 19 years of age or younger. About half were between 20 and 29. Only 6 percent were 30 or over.

The wide variation in age among the residents of maternity homes has been one of the greatest problems in developing sound programs to serve the needs of each individual. This is a problem which presents a real challenge to maternity homes. The age, the personal adjustment, and the previous cultural and social background of the girl influence the manner in which she meets this new experience.

Considerable variation was shown in the extent to which group work and recreation was being used. To be sure there were differences in opinion regarding the value of group work. But there was also recognition of the needs of the girls for a constructive group experience. This was expressed in the type of programs.

One home stated that the girls wanted to express their own ideas and the staff tried to provide ample opportunities for them to do so. Another said the girls were "free to use leisure-time activities as they wished, either in or out of the institution." Many of the homes raised questions about the difference between planned and spontaneous programs. Could the girls take responsibility for planning? Who should pass on the kind of activities that the girls had? A few of the smaller homes said they did not have a large enough group to have a program. Several homes didn't believe a plan was needed if enough free time was allowed during the day schedule. One home thought individual hobbies were preferable to group activities since the girls might form undesirable relationships in the group without careful supervision of staff. A few homes thought the short period of time spent by the girls in the home and the continuous turn-over prevented any planned program of group work.

Although differences in the use of recreation were reported, most of the homes agreed that the girls wanted an opportunity to choose and develop individual and group interests. Of great significance was the decreasing use of recreational opportunities as rewards or privileges. Most of the homes saw values to girls in group work beyond the superficial use of recreation as a "time filler."

One superintendent said that her observations in the home had made her realize how girls are affected by being in a group setting. Relationships among the girls and with the staff were at the very center of morale in the home, she felt. She did wonder, though, how a small staff could use these group relationships to further the social adjustment of girls—the real basis of all group work in a maternity home.

In many homes Bible classes, sewing clubs, and classes in nutrition, first aid, homemaking, and vocations were given under volunteer leadership from the American Red Cross and from the vocational schools and high schools of the local public-school system. Where academic work was carried out in a class or through private tutoring, girls received transferable credits or high-school diplomas from the local high school.

Most homes reported facilities for reading, games, group singing, card games, picnics, croquet, and so forth. Nearby parks and other outdoor areas were used for such activities as nature study and woodcraft. Naturalists from the public park system were asked to help. A short play was produced by the girls in one home, with the help of a volunteer worker. This led to interest in diction, poise, posture, and clothing.

One home emphasized the house furnishings that girls can make, such as drapes and slip covers, also furniture decorating and art work. Another home included a mimeographed newspaper as an important group endeavor. Puppet making was launched in still another home. Here the girls learned to make the papier-maché figures and the costumes, and finally to undertake playwriting and acting. A variety of talents were used and new skills were learned. The girls shared a positive, creative experience in group living.

Who plans for these individual and group activities? One home reported that a member of the staff was assigned this responsibility. This home used volunteers from the community and also several paid leaders for music, dramatics, arts and crafts. Another home reported that a staff committee shared this responsibility, using available leadership in the community, including the YWCA, Girl Scouts, public recreation department, vocational high school, churches, and so forth. Still another home reported that a board-staff committee took this responsibility. Not many homes reported on the systematic participation of girls in planning, although several said they had committees of girls when these were needed to plan particular events. Girls' councils were used to discuss rules and regulations, a number of homes reported. Someone put it this way: "The girls are always given an opportunity to do planning if there is sufficient leadership among them."

On the basis of all this evidence, it is apparent that the potential strength growing out of the participation of the girls themselves in planning for group activities is not being fully realized. Only through the acceptance of the principle that the girls themselves have a vital part in planning can the full values of group work be achieved.

One home reported that it had secured the services of a graduate student in a nearby school of social work to give group-work leadership to the home three nights a week. Another home said the group-work leadership available through the Council of Social Agencies had been used for consultation in the development of their program. In all these attempts we see a real interest in securing the full value of group work for girls in maternity homes. They also reveal the limitations with which homes are faced in the use of board and committee groups, whose only concept of group work is to supply entertainment for the girls and serve as a liaison with other community resources.

The use of community facilities such as libraries, parks, community centers, churches, concerts, movies, museums, schools, is really basic to the entire program in the maternity home. One home puts it this way: "Girls go unattended into the community; but we exercise our judgment as a staff in selecting the girls who have this privilege." Another home stated that the girls check out when they leave during the day; they may shop, go to the library, and attend movies and concerts with family or friends, provided arrangements have been made for them to do so.

Other homes permit the girls to plan for activities only in the home. They justify this by saying that the girls themselves prefer this seclusion from the public. There also appears to be fear that the girls will be unable to benefit by the opportunity of using community facilities.

Where girls are limited to activities within the home and to contacts with individuals who are brought in to entertain them, the morale of the group is lowered. Some homes report that the girls "don't even appreciate the nice refreshments the club provided for them." Or, they complain, "we asked the girls what they wanted but they didn't seem at all interested." One home said an effort was made to have the girls plan their own activities, but that it didn't work out.

There were considerable differences of opinion on whether activities should be voluntary or required. Some homes said girls were "always expected to be present," because it was embarrassing if they did not come to hear the speaker. Obviously, both the girls and the staff need to discuss this matter. Unless participation is voluntary and choice is provided, the positive values growing out of group work to the girls are difficult, if not impossible, to achieve.

But girls who plan and carry out activities of their own choosing, may benefit greatly from them. One home said they encouraged leadership by the girls—"the kind of leadership that draws other girls into the group planning."

A group-work program is a part—a very important part—of the institutional plan. It follows, therefore, that when girls work too many hours a day or when their schedule is rigid, they cannot be free to know leisure. Choice in time for letter-writing, reading, studying, and use of the kitchen between meals, planting flowers or vegetables, studying music, or serving afternoon tea to friends are evidence of the home's faith in values of choice and wise use of leisure-time interests.

Additional information is collected

In addition to the questionnaire, the committee obtained the cooperation of homes in three different cities in supplying the results of recent group-work projects. In these homes, there seemed to be a unanimity of opinion regarding the importance of using group-work methods.

In a Denver home experimental work along this line was conducted during the year before the current study. It was done by board and staff representatives from the home. An evaluation of the Denver project concurs with the principles already referred to in this paper. The workers stress the need for an appreciation that group work is a way of working constructively with people in groups and not merely a program or a collection of activities.

It is a method which is of great significance for institutions where group living is the essence of the pattern—a pattern in which a recreation program cannot be isolated from other parts of the life of the home.

The evaluation of this project also stresses the importance of the interview with the girl when she comes to the home. This is not an intake interview. Rather it is a part of the girl's general orientation to the home. Through a conference with her, the worker helps the girl see the possibilities through group experience which the home has for her. Directly related to this, of course, is the importance of the right attitude on the part of the staff and their acceptance of the girl's right to service.

In terms of future benefits from the girl's experience in the home, the Denver committee found that the experience in this miniature community could be a turning point in the development of the individual. Although the Denver group found formal school programs difficult to operate, they believed that further thought needed to be given to continuation of school work, possibly with individual tutoring.

Variety in activities was important, for only in this way could choice and freedom be permitted while at the same time certain regularly planned aspects of the program were maintained. Participation of the group in the planning was considered to be of vital importance in the success of the Denver program. Leadership, too, was very important.

The Denver committee stressed the value of permitting the girls to use facilities outside the home. Not only did this help the girls keep a relationship with ordinary life, but it was an important factor in increasing resources for an informal program of recreation and education. The evaluation of this Denver program concluded with a reference to physical plant and facilities. Obviously these, while important, are secondary to a way of work and to leadership that supports the method and philosophy of group work.

In Washington the group-work project was started by a home with the cooperation of the group-work secretary of the Council of Social Agencies, who met with the staff and with some members of the board of directors. They discussed present operations and policies of the home, and the group worker explained the philosophy underlying a group-work program and suggested possible ways of making a transition to newer concepts in the field of group activity. Later, reports from the staff as well as from a visitor who had previously been at the home told of more planning on the part of the girls, of their greater interest in activities and things about the home and the increased initiative which girls took in promoting activities of their choice.

Some principles are stated

The purpose of group work in a maternity home is to use group associations consciously for the personal growth and development of girls. Of course, these girls face individual problems which are the same as those faced by many other girls in the community. But in addition, they face many other problems related to illegitimate pregnancy.

All group work should be based on the interests of the individual girls. These interests vary with age, experience, and social development. And since girls in a home may be of various ages—under 17 to 30 years and over—differences in age must be remembered in making plans.

Some of the girls, if given the opportunity, will suggest ideas and activities that express their own stage of development. Others who have had no experience in recreational activities in their home, school, or neighborhood may not express any choice. Expression of interests should be solicited from all the girls. New interests may come slowly, but any interest that comes out of a girl's need deserves attention. An interest expressed by one girl may encourage others to explore and share their ideas.

A staff member may help a girl develop capacities, ideas, and skills which she may share with other girls. Joy in music, dramatics, arts and crafts, and so forth, comes only to the person who has some satisfying experience in their use. Many adolescents have never enjoyed childhood play or organized group activities. For example, it may be strange to find a young woman in a maternity home choosing childhood games or expressing teen-age interests and ideas. The girls in the home may want a party, without the staff—perhaps because they consider the staff members "adults" and seek "adolescent" privacy from them. When this occurs, the staff should understand the reason for it. Leaders in a maternity home must encourage the expression and spontaneity of interests and ideas. These may be used as positive aids in the "growing up" process of girls.

Participation of the girls in planning

Helping girls take part in group projects, such as preparation of material for house bulletin boards, visitors' day, holidays, or special programs, is an important part of a staff member's job. Some girls need encouragement, counsel, and support when they offer a suggestion. Other girls offer ideas easily but need help in carrying them out. A successful group project gives confidence and encouragement to the girls who contribute to them. A girl may begin by presiding at a meeting, writing a letter for the committee, making an announcement about a program, or planning an important event. Not all girls may develop these skills with equal ease, but each may find some interest that she can share with the group.

Developing group morale

The staff of a maternity home may use group relationships to develop morale. Sometimes a member of the staff, or a girl, mentions the good or bad spirit within the home. Relationships within the group create this spirit. High group morale is not an accident. It is the result of a thoughtful plan which takes into account all the girls in the home and their relationships to each other. For example, a small group of girls may express dissatisfaction with certain rules and regulations. This may result in group pressure and tension. A thoughtful discussion, which

(*Continued on page 63*)

COMMUNITY ACTION HELPS TO SOLVE CHILD-LABOR PROBLEM IN BOWLING ALLEYS

PASQUALE J. CAPUANO, Supervisor of Attendance, Providence Public Schools

EARLY THIS YEAR the problem of young boys from 12 through 15 working late at night in bowling alleys again came to the fore in Rhode Island. All such night work is illegal for children under 16 years in the State, and yet these boys were working regularly until 11 p. m. and midnight. School officials all over the State were reporting the results in terms of truancy, disciplinary problems, and poor school work. Among the bad situations that came up was a serious criminal case involving some boys working in one of the alleys; the case came to the attention of the juvenile court.

This kind of situation has prevailed in the State, as in many other States, since the start of the war production programs, when good jobs were available in business and industry for any boy 16 years of age or older, and the bowling establishments were therefore unable to find pin boys over 16 years of age. Since then the labor market has eased considerably, but the old habit of hiring any boy who drifted into the alleys is difficult to break.

During the war production period it was particularly difficult to enforce the child-labor law with regard to employment of pin boys, because of the difficulty that the bowling-alley proprietors had in obtaining help, and because war workers especially needed the wholesome recreation that bowling provides. During those war years much pressure was put on administrative officials to lower the standards for the employment of children in bowling alleys. Efforts were made to have legislation passed providing for relaxation of the age limit for such employment and for extension of the night-work provision of the child-labor law as it applies to bowling establishments. (Such legislation was introduced in a number of other States and actually passed in a few.)

Employment of young boys in bowling alleys is one of the most difficult child-labor problems that State departments have to deal with.

Since almost all bowling is done from 6 p. m. until midnight, the job of pin boy is practically always a night job. And the work is too often done by younger boys, who especially should not work at night. Night work cuts down a school child's sleep and rest and also affects his school work. Boys employed at night may be so tired that they fall asleep in school, or they may play truant on account of fatigue; and truancy, of course, often leads to delinquency. Some children drop out of school because they cannot keep up both work and school. Employment at night may also keep youngsters on the street at hours such as 1 and 2 a. m. and may subject them to moral hazards.

The work of pin setting is accompanied by considerable accident hazard. It is not uncommon for pin boys to be injured by balls or flying pins. Accident records show many reports of fracture and severe bruises of fingers, hands, and toes, and even more serious effects. And the likelihood of accident is increased by fatigue due to the great physical exertion required in this type of work and the loss of sleep that goes with it.

Enforcement attempts failed

Early in 1947, though the war conditions were past, the State Department of Labor's Division of Women and Children was meeting with little success in its attempts at enforcement of the child-labor law in bowling alleys.

At this point the Rhode Island Advisory Council on Child Labor decided to see what it could do about finding a solution to the problem.

The council is an unofficial organization, which was brought into being by the Consumers' League in 1944 at the request of the National Consumers' League, the National Child Labor Committee, and the U. S. Children's Bureau. Among its aims are enforcement of child-labor laws and better school attendance. The council represents all groups in the State that have a special interest in the welfare of young people. It is composed of men and women representing the schools; the churches; the juvenile court; civic, welfare, and labor organizations; business and industry; and the State departments of education and labor. The superintendent of the Providence public schools is chairman and the Governor of the State is honorary chairman.

At a meeting of the council in May of this year several school superintendents, high-school principals, and attendance officers who had first-hand knowledge of the serious effects of this type of illegal child labor were invited to discuss the problem with the council members. The reports of these school officials convinced the council that some action was needed.

It was decided that the local police in the various cities and towns should be asked to take over the job of regularly policing the bowling alleys to take out any boys found to be too young to work legally. The alleys are licensed by the police, and failure to cooperate could result in revocation of a proprietor's license.

Another meeting of the council was planned, to which the chiefs of police of the cities and towns having the greatest problem were invited, as well as some representatives of the association of bowling-alley proprietors.

By the time this meeting was called, early in June, the member representing the juvenile court, along with school officials of the city of Warwick, who had attended the previous meeting, had worked out a practical solution to the problem in that city and in the bowling establishments across the city line in Cranston, where many Warwick boys had been hired. The juvenile-court representative for that area, the high-school principals, and the chief of police had cooperated in clearing the bowling alleys of all boys under 16.

Then the school officials had followed through by furnishing the bowling-alley proprietors with the names of boys over 16 who were looking for part-time work. This had worked out very well. The employers were pleased to have help in recruiting the older boys, who were more dependable and capable, and they felt that they were cooperating with the schools.

Pin setting in bowling alleys is work that is generally done at night, when young boys like this one should be at home.

Within the space of a month, the alleys in that area, many of which had been among the most troublesome, were fully complying with the law and were inviting inspection by the State Department of Labor. At the request of the chief judge of the juvenile court, the Division of Women and Juveniles of the Providence Police Department had added the bowling alleys in the city to its list for regular nightly inspection.

This success furnished the key to the solution of the problem in other areas.

The June meeting of the council was attended by the officers of the association of bowling-alley proprietors and several of its members, at the council's invitation. A number of representatives of the police departments of the various cities and towns, as well as a representative of the State police also accepted the council's invitation to be present, as well as the school officials who had attended the previous meeting.

A friendly discussion of the many aspects of the problem took place. Everyone seemed sincerely interested in improving the employment situation in the bowling alleys. The proprietors of the alleys agreed that they preferred to employ boys 16 and older if they could get them. The school people brought out the fact that this year, for the first time in many years, there were many boys 16 and older looking for work and that very few job openings were available. It was agreed that the schools in the different parts of the State could help recruit pin boys old enough to work at night legally. Then the bowling-alley proprietors who had difficulty finding boys 16 and over to work could apply to the local school offices for prospects.

The Division of Women and Children of the State Department of Labor is following up on this program, visiting the school departments to see whether some sort of placement service can be set up in each city and town for boys desiring summer work as pin boys.

Automatic pin setters reported

An interesting development in the bowling-alley business was reported by one of the proprietors who attended the meeting. He reported that an automatic pin-setting machine has been developed, which will eliminate the need for employing pin boys, as it will set pins automatically, and does not need an employee to help in its operation. Any establishment which has a 12-inch clearance back of the alleys may have such a machine installed, according to the report. The speaker further said that the machines will not be for sale, but will be installed on lease. The rent will be set according to the amount of use the machines get, he continued, and the cost will not be more than the amount paid now to the pin boys.

Since the job of pin boy seems to appeal chiefly to boys that are too young to work legally at night, and since boys 16 and over who are old enough to work legally often find the work distasteful and may refuse the job even though no other work is available, an automatic pin setter would undoubtedly offer a happy solution to a really serious and very knotty problem of long standing. Until these machines are available, however, pin boys are needed.

The action of Rhode Island's Child Labor Advisory Council in this situation is a fine example of the effectiveness of joint action by all interested groups in the community. It also demonstrates the value of this kind of organization, which furnishes a clearing house for knowledge concerning the services available in the community from many agencies to do a particular job which needs doing.

Reprints available in about 5 weeks

THAT CHILDREN IN WAR-TORN COUNTRIES MAY GO TO SCHOOL

HAROLD E. SNYDER, Director, Commission for International Educational Reconstruction

MILLIONS of children in war-devastated countries in Europe and Asia are not in school. And large numbers of those that are in school are sitting on floors in cold rooms, with no textbooks, no paper or pencils, no blackboards or chalk. The schoolroom is often in a church or in a home, as many of the schoolhouses are no more. A typical report on what happened to the schoolhouses comes from the Philippines: "Whenever the enemy soldiers camped, the first buildings they occupied were the schools. Their first act, after taking over, was to build a fire and use school desks, chairs, tables, bookshelves, and books for fuel. So that, even if a school building was miraculously spared, it was a mere shell, with no equipment."

A high percentage of teachers and other professional workers in the devastated countries lost their lives during the war. Many of those who remain are still suffering physically and mentally from their experiences. All are handicapped by lack of training and by loss of contact with developments in their fields during the war years. All are working without even a minimum of the materials needed.

The countries in which these things happened are striving hard to rehabilitate their educational systems, with the help of people in more fortunate lands. A few countries have made excellent progress. Conditions in Norway have improved so much that the Norwegians hope to complete their rebuilding and equipping of schools with only minor help from outside their country. Denmark has had similar success.

But the educational needs of most of the countries are still tremendous and urgent, not only in elementary and secondary schools, but in colleges and universities.

Basic relief in the form of food, clothing, and medical supplies must come first. However, we must not stop there. We must help the devastated countries help themselves by assisting them to obtain the knowledge and skills needed to build the peace. Teachers and other leaders abroad appeal to Americans recognizing the vital importance of education to aid them in restoring educational opportunity and in reclaiming the "lost generation" of children, who have had little formal education during the war and who have been subjected to totalitarian propaganda.

In the United States more than 300 voluntary organizations are helping in various ways to rebuild these shattered educational systems. These organizations are of many types—educational, relief, social service, religious, and civic. Some contribute books, periodicals, school supplies, library or scientific equipment, or money. Some establish recreation-camp programs: others, educational voluntary-service projects, in which young people of several lands join with local persons in rebuilding schools and other public buildings. Some provide fellowships, scholarships, or study grants. Some also send food, clothing, and medical supplies to children and young people, and their teachers. Many of the gifts go to displaced persons.

The work of these many organizations is coordinated by the Commission for International Educational Reconstruction, called CIER for short. This commission, established late in 1946 on the initiative of the American Council on Education, includes representatives of a number of educational and other groups. It is a nongovernmental agency, which has been designated by the U. S. National Commission for UNESCO (United Nations Educational, Scientific, and Cultural Organization) as the agency to stimulate and coordinate American voluntary efforts on behalf of education in the countries damaged by war.

The commission publishes a report called "CIER Handbook," the second edition of which has recently been issued. This handbook lists the 300-odd organizations whose work for educational reconstruction is coordinated by CIER, and gives a brief summary of the activities of each during a specified period. It also includes many of the agencies' estimates of the dollar value of their contributions during the period.

CIER also has published, in cooperation with UNESCO, a 20-page booklet entitled "Going to School in War-Devastated Countries," by Leonard Kenworthy, who is a member of the Secretariat of UNESCO and author of "The Teacher and the Postwar Child," one of UNESCO's first publications for use by teachers in the war-devastated countries. (This publication, which is now out of print, was made possible through a generous gift of the Greek Government to the Technical Subcommittee of UNESCO.) "Going to School in War-Devastated Countries" is planned primarily for distribution without charge by American organizations engaged in international educational reconstruction, and it is available at cost to such organizations from the commission. CIER also issues bulletins of information, which may be had free.

In April of this year, CIER, with the cooperation of the American Council on Education, the National Association of Secondary School Principals, the National Catholic Educational Association, and the National Council of Independent Schools, appealed to the graduating classes of American schools and colleges to make a gift toward reconstruction of education in the devastated countries. More than 100 schools and colleges made contributions. A similar appeal will be made to the classes of 1948.

A steady increase in gifts by the various organizations has taken place that is highly gratifying, but it must be remembered that, despite this generous response, millions of persons in the devastated countries are still lacking in educational opportunity. UNESCO and CIER urge that projects carried out this year be continued and expanded during the coming year and that many new activities be initiated. Organizations interested in developing new projects may write to CIER, 744 Jackson Place NW., Washington 6, D. C.

Reprints available in about 5 weeks

FOR YOUR BOOKSHELF

CITIZENS LOOK AT THEIR HEALTH SERVICES FOR CHILDREN. Citizens' Committee on Children of New York City, Inc. 136 East Fifty-seventh Street, New York 22, N. Y., 1947. 16 pp.

The Health Section of the Citizens' Committee on Children of New York City, Inc., under the chairmanship of Dr. Donovan J. McCune, has issued a report on the city's planning for health services for children.

The report refers to the gains that have been made in reducing maternal and infant mortality and in extending and improving health services for children. However, it also points up certain inadequacies and failures in New York City in meeting many of the important health and social problems among children and their families.

A set of recommendations are included in the report which can serve as guides to citizen groups in working for further improvement in the health services in New York City. Not all will agree with some of the recommendations particularly those relating to school health services, since many are of the opinion that such services should be fully available to all irrespective of economic status.

The report closes with a practical discussion of next steps and with a challenge to various public and private agencies to coordinate their efforts in joint planning on behalf of New York City's children.

A. L. Van Horn, M. D.

DENTISTRY; an agency of health service, by Malcolm Wallace Carr, D. D. S. Commonwealth Fund, New York, 1946. 219 pp. $1.50.

Addressed to three kinds of readers: The intelligent layman, the dentist, and the physician.

PUBLIC HEALTH: A career with a future. American Public Health Association, 1790 Broadway, New York 19, 1946. 29 pp. 10 cents.

A statement of the need for workers in public health and of opportunities, advantages, and satisfactions offered by such service is given in this pamphlet. Our attention is called to the increasing security in public-health careers because of the efficiency of the services being rendered, the growing public-health consciousness of the people of the world, and the inclusion of public-health workers under civil service. An equally frank statement of the possible disadvantages of a public-health career also is given.

The publication includes descriptions of intensely interesting and challenging services in a wide variety of fields in both official and voluntary public-health agencies. The organization of a typical city health department is described, including the duties, qualification requirements, and salary range of each type of personnel. There are listed the estimated numbers of positions of different types available now; schools where the required training for these positions can be acquired; and the public-health positions open to individuals with limited training of various types.

This is an inspirational as well as a highly informative statement that should be exceedingly helpful to those who contemplate entering the field of public health.

Clara E. Hayes, M. D.

JUVENILE DELINQUENCY; a critical annotated bibliography, compiled by P. S. de Q. Cabot, Ph. D. H. W. Wilson Co., New York, 1946. 166 pp.

This compilation includes 972 annotations, representing a selection from several thousand references considered.

SOCIAL WORK YEAR BOOK 1947; a description of organized activities in social work and in related fields. Ninth issue. Edited by Russell H. Kurtz. Published biennally. Russell Sage Foundation, New York, 1947. 714 pp. $3.50.

Topics treated for the first time are Canadian Social Work and Psychological Testing in Social Welfare, and, for the first time in recent years, Alcoholism.

New titles for some of the activities discussed in the previous issue are Adoption; Child Labor and Youth Employment; Foster Care for Children; Guidance and Counseling; Migrants, Transients, and Travelers; Personnel Standards in Social Work; and Racial Programs in Social Work.

The following articles have been reprinted by the U. S. Children's Bureau from the Year Book in limited quantities, for distribution by the Bureau. Single copies may be had without charge.

Adoption.
Boys' and Girls' Work Organizations.
Camping.
Child Labor and Youth Employment.
Child Welfare.
Crippled Children.
Day Care of Children.
Foster Care for Children.
Juvenile Behavior Problems.
Juvenile and Domestic Relations Courts.
Maternal and Child Health.
Social Group Work.
Youth Services.

STATE CHILD-LABOR STANDARDS: a State-by-State summary of laws affecting the employment of minors under 18 years of age, by Lucy Manning and Norene Diamond. United States Department of Labor, Division of Labor Standards, Child Labor and Youth Employment Branch. Child-Labor Series No. 2. Washington, 1946. 182 pp.

This publication brings together in brief summary form for each of the States, as well as for the District of Columbia, Alaska, Hawaii, and Puerto Rico, the more important provisions of State child-labor and compulsory school-attendance laws which affect the employment of minors under 18 years of age.

The summaries have been prepared in loose-leaf form, so that pages may be removed and new pages added when revisions of the laws occur.

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Reprints Available

A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, are available for distribution. Single copies may be had without charge.

Child Guidance Clinic. By Samuel Whitman. *Hygeia*, September 1945.

Children's Services in the Community. By Elsa Castendyck. *Social Service Review*, September 1946.

Foster Home Care in Rural Areas. By Louise Gilbert. *Journal of Social Casework* (New York), February 1947.

Psychiatry for Children. By Lawson G. Lowrey, M. D. *American Journal of Psychiatry*, November 1944.

Relation of Pediatric Preventive Medicine to Mental Hygiene. By C. Anderson Aldrich, M. D. *Psychosomatic Medicine*, November 1945.

Squint in Children. By Dan M. Gordon, M. D. *Journal of Pediatrics*, November 1946

There Is No Substitute for Family Life. By Lauretta Bender, M. D. *Child Study*, Spring 1946.

IN THE NEWS

Oscar R. Ewing Becomes Federal Security Administrator

On August 27, 1947, Oscar R. Ewing of New York was sworn in as Federal Security Administrator, to succeed Watson B. Miller of Indiana. Mr. Miller, who became Administrator in October 1945, resigned on August 18, 1947, to become Commissioner of Immigration and Naturalization in the Department of Justice.

New York Extends Life of Its Youth Commission

New York's Legislature has extended the life of the State Youth Commission to July 1, 1950, and has granted it an appropriation of about three million dollars covering the fiscal year ending March 31, 1948.

The Youth Commission was established by the legislature in 1945 for a period extending to June 30, 1947. It serves the State by analyzing problems relating to the prevention of juvenile delinquency and by making State grants available through youth bureaus or other planning groups to cities and counties for projects benefiting children and youth. Among the requirements made of a community receiving such a grant is that it shall have planned a program that meets the needs of its own children, so that the State funds will be effectively integrated with existing public and private services for children and youth. The commission recommends also that each municipal program receiving State funds to be planned with broad community support and participation; employ skilled leadership; and have a plan for continuing financial support on a sound basis, such as within the community's regular tax program.

The sum of half a million dollars has been allocated by the New York State Youth Commission to more than 340 municipalities to assist them in providing more adequate recreation services for youth.

The Youth Service News, which was launched by the State Youth Commission in January 1947 as an occasional publication to report current happenings and ideas in the commission's field, has reported on an adaptation of a multiple-criteria technique to be used by teachers in efforts toward early detection of pupil maladjustment. The method was tested in the schools in 10 pilot communities by the commission's education division in cooperation with school administrators and teachers. In connection with the study the education division has published a teachers' manual on pupil adjustment.

As one of a series of research studies planned by the Youth Commission, the probation officers of six counties on March 1 began a 3-month study of the relation between school maladjustments and home problems. For this survey the commission prepared a check list for use by probation officers.

"Children in Trouble" is the most recent of the films pertinent to the problems of youth that have been made available by the commission through the State department of commerce to groups and communities throughout the State. The film opens with an account of the cost of crime, portrays some of the causes, and concludes by showing some methods of prevention. Another film, "Playtown, U. S. A.," which shows a successful recreation program in a typical American town, is also among the available films.

Oregon Committee Studies Youth Guidance

A joint interim committee on youth and youth guidance was authorized by the Oregon Legislature in March 1947. This is a five-member committee—two members from the Senate and three from the House—instructed by the legislature to study the problems related to youth and youth guidance and to report to the 1949 legislative assembly. It will give special consideration to the recommendations by the joint interim committee on juvenile delinquency, made to the 1947 legislature.

The committee will hold public hearings and make necessary surveys.

England Adopts Short Form of Birth Record

A bill was passed this spring in both Houses of the English Parliament permitting any registrant to obtain an abridged birth certificate. The new short-form certification contains the items needed as proof of name, date of birth, and birthplace. It omits information on parentage or adoption.

Prior to the passage of this short-form law the only certification which was issued in England contained the items of: when and where born, name, sex, name and surname of father, name and maiden surname of mother, rank or profession of father, name, description, and residence of informant, when registered, signature of registrar, and baptismal name if added after registration of birth.

A short-form certification has been in use for some years in Scotland and in Australia and has become the usual certified copy when birth certificates are requested.

SOURCE: *The Registrar, June 16, 1947*

Mississippi Children's Code Commission Meets With State Committee on Children and Youth

The Mississippi Children's Code Commission met in joint session with the Mississippi State Committee on Children and Youth, April 2. Information provided by R. Catherine Bass, executive secretary, shows that the commission has four committees at work on the State's needs and essentials in their respective fields, as follows:

The committee on adoptions and related subjects is evaluating the present laws of the State in the light of good adoption procedure.

The committee on licensing and supervision of hospitals and other institutions providing maternity care has recommended that the State department of health be authorized by law to certify sanitary requirements for hospitals; that the State department of welfare certify all institutions acceptable for the placement and adoption of children; that persons unable to pay be admitted to hospitals under the rules and regulations of the State department of welfare, with their care paid for on a per diem basis; and that provision be made for adequate maternity-hospital personnel.

The committee on employment of children is working for a 16-year minimum-age law; and the committee on regulation of school attendance is working to make available to all children in the State 8 years of elementary school and 4 years of high school, together with public transportation, free textbooks, and a broader curriculum. The school law toward which the committee is working would also require that children attend the full length of the term, that those not attending school on account of alleged incapacity to learn be tested, and that those kept out of school to work be reported for investigation and assistance.

Helping The Unmarried Mother

(*Continued from page 57*)

allows for expression of feelings of the group is not only wise but necessary. Through such discussion, positive suggestions may be offered by the group. Sometimes this is done in relation to problems of living arrangements, meal schedules, use of facilities, hour of rising, work activities, rest periods, and free time.

Girls can be helped to participate voluntarily with others in activities of their own choice. One girl may gain most by acting as chairman of a committee; another may spend considerable time in a sketching class. Whatever the interest may be, it can be shared, enjoyed, and valued.

Skilled and understanding leadership must be provided for group discussion. A leader must understand her part in group discussions if she is to help the girls. Freedom of discussion is essential to sound group decision and morale. The staff can only contribute successfully to these discussions to the extent that they are objective. If a leader expresses a personal reaction she prevents the girls from participating freely.

The meaning of group relationships

Group relationships during the period of stay in the home can be a basis for feelings of security and acceptance. "Belonging" in a group may help a girl adjust to the home and to her own situation. Undesirable or unsuccessful group experience may actually prevent this individual adjustment. Many of us have observed a girl who is trying to find her place in a group. Often she begins by calling persons by their first name, by suggesting conversation, or by wanting to share something, however small, with other girls. If she wins approval she begins to establish positive relationships in the group.

Some girls are unable to get along with others. We have seen them often: Mary, a sensitive girl who takes offense at a slight bump in the corridor, or who escapes from the group in the parlor because she fears they do not want her; Henrietta, who is noisy and loud about things and often irritates the group. These are the girls who need help the most. A shy girl is often overlooked because she is so agreeable. An aggressive girl is sometimes disliked by the staff as well as by other girls because she is difficult to get along with.

Sometimes unusual physical fatigue, emotional tensions, or even group hysteria may result from too much time spent in groups; provision should be made also for quiet activities such as reading, writing, studying, the development of individual hobbies. Libraries, lounges, small parlors, workshops, and music rooms may meet the need for release from excessive group pressure that occurs in institutional living. Girls should be free to go to their own rooms whenever they wish.

The use of group work in case treatment for an individual requires understanding of the problems troubling her and of her feelings about them. Sometimes maternity homes, like some other institutions, ask the girls to conform to a pattern. The girls may be expected to show unnatural solemnity or superficial dignity. The board and staff of a maternity home must make it possible for girls to have spontaneous enjoyment when it is natural for them to do so. They must make it "all right" for adolescents to have parties. The expression of happy feelings can be used positively. Artificial and rigid conformity or unnatural expression only increases the problems which an individual faces.

Staff responsibility for the development of a group-work program is shared by (1) the superintendent who gives administrative leadership; (2) staff with group-work responsibilities; (3) a group worker or a recreation leader; (4) board members and board committees; (5) volunteers and staff from community agencies. If the institution does not have a group worker on the staff, the superintendent may delegate this responsibility to one of the staff members or to a staff committee. Volunteer workers from community agencies and schools of social work can also provide leadership.

Employment of a group leader will depend upon the needs of the maternity home. It may also depend upon what services are available from the community. If such a person is employed, she should have sufficient knowledge of the use of group work leading to the personal and social maturity of the girls, and skills to develop a voluntary program based on their interests. Appreciation of the special problems in maternity homes is also essential. Group leaders must also have an understanding of the work of other professional workers in the home such as the doctor, nurse, case worker, and so forth. Sensitive, imaginative leadership is required to carry out any planned program.

In planning recreational services for girls in maternity homes, then, emphasis should be placed on development of programs within the institution as well as skillful use of community resources.

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• CALENDAR

Oct. 15–27—World's Council Meeting of Y. W. C. A. Hangchow, China.

Nov. 2–7—American Occupational Therapy Association. Annual convention. Coronado, Calif.

Nov. 3–5—National Society for Crippled Children and Adults. Chicago, Ill.

Nov. 9–15—National Hearing Week. Further information from American Hearing Society, 1537 Thirty-fifth Street NW., Washington 7.

Nov. 9–15—American Education Week. Further information from National Education Association of the United States, 1201 Sixteenth Street NW., Washington 6, D. C.

Nov 9–16—International UAW–CIO. Atlantic City.

Nov. 12–13—National Committee for Mental Hygiene. New York.

Nov. 16–22—Children's Book Week. Twenty-eighth national observance. Further information from Children's Book Council, 62 West Forty-fifth Street, New York 19, N. Y.

●

A closed play street gives our October cover boys a fine chance to play safely. The photograph is by Esther Bubley.

Other credits:

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Page 55, drawing by Constance Dillon.

Page 59, photograph by courtesy of McCall's Magazine.

WE NEED TO KNOW MORE ABOUT EUROPE'S CHILDREN

Europe's children are hungry—yes, very hungry—and this winter there promises to be even less for them than in other years.

Hunger, though, is not all that is the matter. Some insight into the problem comes from a report brought to the Children's Bureau by Helen Groot, a social worker from the Netherlands, a country traditionally a symbol of stability and order. The story is repeated over and over again with little change.

The emotional insecurity in which the children have spent their lives has left its mark. Miss Groot speaks of 4- and 5-year-olds having "nervous breakdowns," one way of describing their going to pieces in the face of threats to their security which they cannot understand. The security children need is not to be had.

Family relationships, for one thing, are very much mixed up, with many elements that bear hard upon the children. The able-bobied men were taken from their families for work in Germany, and, over the course of years, sometimes family ties weakened. The men came home—or they did not come home—and it was difficult to take up the old ties again.

So they have done what other people would do under the circumstances; that is, make the best arrangement possible. Not all the children in the same family unit have the same mother; or, the other way around, not all have the same father. Sometimes they are not even of the same nationality or race. Some of the children have no kinship ties with those who are looking after them. For a good section of the population the neat little family unit is gone. What has taken its place is often an unstable assemblage of adults and children.

Families live under conditions that would be hard enough even if all else were right. Food is hard to come by. So is housing. Under such conditions, with all that the deprivation and the crowding mean in terms of people getting on one another's nerves, the children often have little chance for any security. And, at a time when the community most needs to gather up its resources to bolster the home, the community is helpless. It struggles, for one thing, with the problem of getting and keeping the children in school, with getting food and housing for them, and such immediate matters. It lacks the money, the personnel, and the facilities to do more than make a gesture in supplying badly needed social services.

This break-down of social responsibility, as far as children and young people are concerned, has long-range implications for all of us. These young ones will pull through, for people somehow live, but what kind of men and women will they be? We ask this question repeatedly concerning our own children and youth, but we must extend that concern to these others, too. Common humanity should lead us to give food and money so that something can be done to meet the immediate need; enlightened self-interest should lead us to do more to strengthen such international channels as we now have, whereby help may be brought to these children.

Katharine F. Lenroot

KATHARINE F. LENROOT
Chief, U. S. Children's Bureau

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THE CHILD

NOVEMBER 1947

Study and Treatment Homes for Troubled Children

MARTIN GULA, *Director,*
Evanston Receiving Home of the
Illinois Children's Home and Aid Society

STUDY and treatment homes for troubled children are a new tool in the child welfare and mental hygiene fields. Like other new tools the use to be made of them is not always clear. To some they are looked upon as a means of bringing about a "quick cure" in the child's behavior. Others would use the study home as a substitute for some other service which is inadequate, or lacking, in the community. In still other instances, the name, not the tool itself, is appropriated for an existing institution or one being planned. In reality, the study and treatment home is a supplementary tool, but an increasingly important one, in a comprehensive program of services for children.

To describe a study home, briefly, it is a place where a carefully selected group of disturbed children are brought together in a home atmosphere under the care of adults with special qualifications. The purpose of their stay is to provide an opportunity for a diagnosis of their difficulty on which treatment can be based, and plans can be made for permanent care.

The study home is not by any means for all children who are showing difficult behavior problems. Good basic case work, as we know, calls for early detection of the emotional problem and treatment within the home setting. However, study and treatment in the child's own home is not always possible. Parents are frequently inflexible. Sometimes the symptoms persist in spite of case work. What then needs to be determined is whether the young person's behavior is predominantly reaction to a provocative family, school, or neighborhood situation or whether it is a reaction to disturbing conflict within the young person himself. The need is to arrive at this differentiated awareness before too many changes of environment are tried.

Although there are exceptions, and each situation demands its own analysis, disturbed behavior that is due chiefly to environmental factors shows itself usually in response to a specific person, or setting, and in an isolated form. On the other hand, behavior that is due to internal conflicts appears in more than one form and in response to several persons or settings. A child, for instance, who steals at home because of the lack of maternal affection and the hostility of a punitive father, may very well be treated in a foster home if it can satisfy the needs that were not met in his own home. But, if in that foster home the foster father is punitive like the child's own father, then the affection of the foster mother may not serve as a "corrective."

Even for those children whose behavior is the result of an inner conflict of recent pattern, a foster home may be tried, provided the child can be helped by a case worker or psychiatrist and provided the community can tolerate his behavior. At least the foster home can be tried as a "therapeutic test."

However, for certain children whose patterns of disturbance are of long standing and who need individual treatment the foster home or institution cannot be tried, even as a "test." They are the children for whom the study and treatment home may be used.

Our practice in the Evanston Receiving Home indicates that such residence is particularly useful for the following:

(1) *The disturbed child who cannot be reached through case-work treatment in the community.* In this group are those who are reacting to inner disturbances that have persisted over long periods, children who cannot respond postively to adults in a foster-care role, but who may be able to respond in a group. Many children who are too frightened, inarticulate, infantile, and resistive to form a therapeutic relationship with adults can relate, initially at least, to other children.

(2) *The child whose symptom patterns cannot be tolerated by the foster family, school, or neighborhood.* In our study and treatment home we have

Condensed from paper given at the National Conference of Social Work, held April 13–19, 1947, at San Francisco.

had children who, seemingly without provocation, would break forth in severe tantrums or rages in which they would break windows and tear clothes. Others practiced sexual delinquency of a direct nature. Some had night terrors. Some set fires. Many had involved stealing patterns. One girl compulsively combed her hair 20 times before going to school. These symptoms, and a host of others that cannot be tolerated in the ordinary setting, make it necessary to provide some special form of care and treatment.

(3) *The child whose symptom patterns need "professional" observation and treatment.* Included in this category are those with symptom patterns such as: (a) compulsion neuroses that need careful, controlled observation of precipitating factors; (b) pseudo-defective behavior with elements of disturbance and mental defectiveness that cannot be differentiated or tested in the community; (c) emotional behavior such as unexplained mood swings—changes that may have a physical basis; and (d) physical behavior that has an emotional basis, such as asthmatic attacks. Careful observation is needed, the kind of observation that can be carried on only in a controlled setting by people with special skills.

(4) *The child who cannot relate to the foster family, community, school, or neighborhood.* This group includes, for example, a girl so worried and afraid that she cannot leave her home to attend school; a boy, approaching adolescence, who is intensifying his aggression against parent persons; and a girl who is withdrawing from foster parents, school and neighborhood groups to such an extent that foster parents are not satisfied with her.

Parenthetically, it assumed that certain groups of disturbed children such as the feeble-minded, the physically crippled, and the emotionally disturbed on an organic base, the advanced delinquent, and the psychotic can usually be diagnosed in the community setting and through community resources, and that treatment services directed to their specific needs can be used. They are not among those for whom a study and treatment home is generally considered.

In selecting those for whom such residence seems indicated, the case worker works under certain conditions. First, she tries to get the picture behind the symptoms in relation to past and present factors in the child's physical, mental, familial, and social development. Second, the diagnosis and the treatment plan are tentative until tested in the child's home, or until a "therapeutic test" is made in the foster home, or later in the treatment center. Finally, specific reasons for using the treatment center must be arrived at.

The study home

Operation of a study and treatment home varies in emphasis in relation to its sponsorship and to the community need.

Our residence, the Evanston Receiving Home, is utilized as a diagnostic and treatment center for exceptional emotional deviations of children, in a planned residential group. It is under psychiatric direction and uses specific personnel in a specific program. It is a supplementary and integrated tool in the total program of the Illinois Children's Home and Aid Society.

This Society is a private, State-wide, nonsectarian child-placing agency that has under its care some 1,800 dependent children. It uses foster homes primarily, and, in addition, institutions other than its own residence, the need of particular children determining the placement. Case workers assume responsibility for the child as long as he is with the agency.

At any point of the youngster's stay with the society, Dr. Margaret Gerard, the psychiatric consultant, is available for conference. At intake a diagnosis is made, and during the child's stay in a foster home or an institution, consultation is given. Consultation also takes place when the child is considered for the study and treatment residence.

The psychiatric consultant leads seminar discussions at which case presentations by the society's social workers are used for a review of psychiatric concepts underlying their work with the youngsters.

That, then, is the framework in which the study and treatment home is operated.

Diagnosis and treatment in the study home

Some study and treatment residences are primarily for diagnostic study within a brief period. Others combine diagnostic and treatment services. In both, the group residence is used to provide experience in living with others under controlled conditions.

The setting quickly loses its artificiality. The child soon uses the staff as parents and the other children as siblings. He usually directs toward them the fundamental emotions he directed toward his own parents and other significant persons in his earlier experience.

In some homes a "repressive" atmosphere is sometimes developed and conformity is demanded from the child. Some homes, on the other hand, have an "indulgent" atmosphere that demands little conformance. Still others provide a flexible "expressive" atmosphere in order to bring out the best in the child.

Our approach is one of treatment, and in it, what is done and the attitude taken is related to the boy's or girl's individual emotional needs at a given time. Within this approach some self-indulging children are helped to impose limits on themselves. Those who have imposed upon themselves severe conformity are encouraged to relax. In other words children with different needs are given different treatment.

The practice at the Evanston Receiving Home is to observe as many areas of the child's daily living as will help evaluate his personality, recognizing that the dynamic trends are more important than the static picture. Staff members, the residence personnel, the recreational workers and others in contact with the children make their observations of the child's behavior in relation to the initial reasons for his referral and acceptance. They inform the director as soon as possible after the behavior occurs, and he, in turn, notes their observations in a "log." This recording provides a basis for summarizing behavior trends. Case workers refer to this log prior to each interview with the child.

After a month's time the psychiatrist, case worker, case-work supervisor, director of the residence, and the house staff usually confer. This meeting is

The house mother plays a real mother's role.

A boy needs a place of his very own for "tinkering."

for the purpose of arriving at a causal base for the youngster's disturbance in order to establish a relationship between his inner needs and the symptom picture, and to formulate a treatment plan to meet those needs.

The case worker reviews the child's history giving her tentative diagnostic formulation. Her report covers her interviews with him and brings out their content, trend, and significance.

The director summarizes the trends in the child's behavior in the group, school, and neighborhood, basing it upon the observations of the residence staff. Such significant information as the following is reported: the child's interests; his physical mobilization, eating habits, and use of time, sleep, and money; his emotional fluctuations and reaction from frustrations; his attitude toward boys and girls; his feelings about the case worker, and his verbalized feelings about his parents and their visits. Detailed information is also brought in about his response to school, work, and material possessions.

The psychiatric consultant, who presides over the conference, then helps the group formulate their diagnostic and treatment plans.

Following such a conference, the child's stay in the home may be terminated if it is felt that some other service can better meet his needs. If, however, diagnosis indicates that his problems are due to inner conflicts and that residence can be a constructive experience, then a treatment plan is carefully elaborated.

The case worker is given specific suggestions for handling her interviews. Likewise the resident staff is advised as to how to handle the child in the residence, and how to deal with problems that arise in the school and neighborhood. Every 6 or 8 weeks the case is reviewed and treatment progress evaluated. Throughout these periods the case worker interviews the child weekly and interprets developments in his behavior to the house staff.

As treatment in the home is being concluded, a transition is planned and executed in accord with the child's need. That may be a return to his own family, a move to a foster family or institution, or in the case of the older ones, jobs may need to be found so that they can become self-supporting. The setting and the type of persons that will best serve the child's needs are determined on the basis of the study and treatment of the child while in residence. That information gives the worker a sounder basis for predicting behavior than could be obtained in the community setting.

Role of the case worker

Throughout her work with the child, the case worker not only refers to the "log" for recent observation of the resident staff prior to her interviews, but she also records the content of the interviews for their effect on the child's behavior. The room in which the interview is conducted is provided with a glass panel in order to forestall interruptions. Play equipment—art materials, dolls, soldiers, music, construction sets, and other media—is at hand for the workers to draw upon as part of therapy. On one wall is a hand-painted circus mural which subtly introduces father persons, mother persons, children of various ages, and dogs, all busy riding a merry-go-round, or watching it. The youngster being interviewed will express feelings toward different figures in the mural in the same indirect way in which the child uses play symbols.

Case workers see each child at least weekly, the disturbed children more frequently. Some case workers have more than one child under care at the same time. As part of their individual treatment program, such workers learn to handle the sibling feelings arising in each child.

The case worker carries total responsibility for the child as a staff member of a child-placing agency. She obtains the initial and subsequent history of the child in his family setting, maintains a relationship with other agencies and resources, clears with and interprets to the houseparents the treatment movement for a particular child, and at the same time actively treats the child through interviews, manipulation of resources and play therapy. All developments are recorded. When part-time psychiatrists are used, they may undertake some direct treatment.

Although the case workers and the psychiatric consultant are not in residence at our home, they do not dissociate themselves from the resident group and the staff. They are part of the home and work through it.

Throughout the treatment it is recognized that a concept gained through the understanding and skill of a case worker must be lived through "in experience" if the child is to be able to relinquish old feelings and begin to assimilate new ways of behaving. The child's ability to reenact earlier life experience and have it handled in a constructive way by adults and other children in the residence is essential to a sound treatment program.

The residential group

Study and treatment homes vary in size, and in the age, composition and basis for their groupings. The Evanston home includes two buildings, housing 34 children between 6 and 16 years of age. They are in groups of 8 to 12, with a trained housemother and housefather. Part-time university students living at the home come to represent big brothers and sisters. Boys and girls have separate living quarters, but are free to mix for dining, recreation, and other activities. Dormitory space is gradually being broken down into single and double rooms.

Planning so that the group has constructive elements is as important to effective study and treatment as is good case-work interviewing. In the last few years of practice many principles have emerged on which such a group must be based. Some of these still need further testing.

Our experience shows that the following principles are of first importance:

(1) In making up a group, developmental rather than chronological age is more important.

(2) The group setting and what it means to live in it should be interpreted to each child as an important step in the group treatment. Group treatment, though, can precede, accompany, or succeed individual treatment.

(3) The sooner accurate therapeutic goals are fixed, the more effective the initial and subsequent handling of the child in the group.

(4) The child, if possible, should also have a therapeutic goal.

(5) The greater the difference in disturbed behavior patterns of the individuals, the more active the adult must be in the group situation.

(6) The group is a substitute sibling setting and positive relationships should be stressed. Individual needs should determine choice of roommates, dining table grouping, recreation groups, and so forth. Unwise use of competition can be injurious.

(7) The adult must be trained to observe group cross-currents, to understand their effect on individual children, to predict the impact of new children, and to transfer children who prove to be consistently injurious to others in the group.

(8) Children vary in the emotional use they make of adults, and this use may change from day to day.

(9) The child who desires to remain in the group must adjust some of his personal way of living to the mores of the group. Initially he may repress some attitudes and express others.

(10) What is permissive can be extended in those groups for which children are chosen with the foreknowledge that they will modify their aggression.

(11) Certain disturbances do not "live well" together, whereas other disturbances depend on a social group for treatment.

(12) A "group" equilibrium must be maintained. Conflicts are important but should not be continuous. Constructive leadership in the group should be stimulated.

The community and the home

The community setting must be taken into account for the way in which it influences the program of the group residence. If the community schools are to be used along with the churches, recreational and other resources, then that fact must be taken into consideration before the child is admitted, for the residence can treat only as much disturbed behavior as the neighborhood will tolerate. Schools frequently will tolerate as much disturbance as they are prepared for ahead of admission and no more. Similarly, the group, or children in the group, cannot be precipitated into neighborhood groups. One must know in advance how the community resource can be related to the child's needs.

Thus, a residence which depends on community resources may have to modify its program somewhat, but, it gains in being able to draw upon the coterie of specialists so indispensable in treating disturbed children: psychiatrists and psychologists; medical specialists; educational tutors; and persons on the staff of referring agencies, hospitals, clinics, churches, and other resources.

As far as possible, the residence should integrate its own children with neighborhood children as they show readiness and capacity for it. Resident children should be able to bring in community friends. Adolescent girls and boys should be permitted to invite their "dates" to the residence. Mixed group parties should be used when children can utilize the experience.

The staff, likewise, should have community ties. For instance, the staff of the Evanston Home participates in parent-teacher groups, the Council of Social Agencies, youth councils," and other local groups.

Characteristics of personnel

A resident program is dependent upon a staff of persons with specific qualifications.

The Evanston program, which provides for 32 children, draws upon a staff that includes the following: a director, secretary, three full-time housemothers, a housefather, two assisting housemothers, and several university students who receive room and board in return for 16 hours a week in recreational activities. A handyman, cook, and serving assistant are also on the paid staff. Additional help comes from the community on a voluntary basis: a men's group gives shop instruction; a women's group instructs in cooking; and Northwestern University students assist the staff in art, music, drama, and craft activities.

The psychiatrist, through case conference and review attended by the resident staff, indirectly influences the treatment atmosphere of the residence.

Staff efforts are integrated so that a consistent treatment of the specific child is followed.

The director of the residence is frequently used as a guiding person by the resident staff, case workers, and the community. Such a person should be trained in social work, psychiatry, education, or medicine. The author's own background of group work, psychiatric case work, and professional social work training has helped him understand the application of case work and group therapy in the treatment of disturbed children, and has also helped him to integrate function, plant, program, personnel, and finances in building and implementing this type of service for children. A sustaining leadership, rather than an authoritative personality, is desirable in a director.

The substitute parents must be mature adults whose own emotional patterns are recognized and have value in terms of the child's reacting behavior. Their interaction with the child must be carefully watched. The housemother and housefather must be able to observe behavior objectively, and to participate in psychiatric consultations, reaching with the others a diagnosis and treatment plan. They must then be able to react to the child's daily behavior in relation to this framework of diagnostic and treatment dynamics. Some of this ability will be brought to the job; some will be gained through training.

These substitute parents should be able to give warmth and dispense firmness in relation to the needs of the different children. They should also have the ability to handle objectively and constructively for the child such behavior as cursing, threats, projected blame, destructiveness, stealing, and the gamut of irregularities that are associated with disturbed children.

Each of the houseparents at the Evanston home is college-trained. One has an advanced degree in education. All have had graduate training in case work, or group work of various kinds. Such training is helpful but the basic need is a mature, flexible person who can respond to children's behavior on the basis of a professional plan.

All others of the staff, paid or volunteer, must be persons mature enough to contribute to the total treatment atmosphere. The cook, for example, should not only be a good cook, but also some one who enjoys children and is ready to accept some disturbance from them.

Program

The program of a study and treatment home is not a "mass" program, but in so far as feasible, it is broken down to meet individual needs. Reliance must not be placed on a mass dormitory, a large dining table, and large group activities, for not many children will be reached in such a setting. A basic framework is necessary, but it must have flexibility.

Our differentiated program provides play and construction materials as a means of draining anxiety and restoring self-confidence in different ways. A woodwork shop, indoor and outdoor athletic equipment, art supplies, classical and "jive" music, sewing equipment, and the like are provided for varied activities.

Each child has his room or part of a shared room and keeps with him, besides his clothing, his own books and toys and the many objects that go with growing up. Children like to "putter" a bit with their own possessions in their own room before retiring. Clothing is individual; mail is personal. Throughout all their experiences the youngsters feel that they, as individuals, count. They are made to feel proud of their "home," and they make social attachments within it and within the community. They come back to visit with pleasure.

A happy group, a minimum of rules, and a constructive use of adults—these together provide a constructive matrix for treating disturbed youngsters. Within this matrix we try not only to eliminate symptoms, but to do away with the inner need for the symptom.

In sum, it should be recognized that the study and treatment home for disturbed children is a new tool. It needs testing under various conditions and with many children before exact values can be proposed scientifically. We have, however, learned this much.

1. The study home cannot stand alone. It must be interlocked with the use of the child's own home, foster home, institutions, and other community services depending on the changing needs of the child.

2. There are no quick "cures" excep for very mild or recent disturbances or those related to specific environment.

3. An institution cannot be made into a study home by a mere change of title but only by meeting the requirements listed earlier in this discussion.

4. This specialized service which may seem prohibitively expensive is not so when the alternative is considered, that is, the expense of foster home replacements for many, to say nothing of the cost of later maintaining the most seriously disturbed children in hospitals, or paying later, in more ways than one, the cost of a neurotic and delinquent adult in the community.

The study and treatment home provides a testing ground by which we can come to a better understanding of disturbed children and their treatment. With each child who is served our knowledge is expanded and deepened. This understanding of the child, obtained in a controlled setting, provides a sounder base for diagnostic and treatment formulation, treatment testing, and actual treatment progress than could be obtained for some children in any other way.

Treatment progress, in some instances, is markedly accelerated. Harold, a 9-year-old who came to the Evanston Home 2 years ago, provides a notable example. He had buried a cat alive and dropped another into an incinerator. He beat other children. He tore his clothes in rags. He set fires. He played truant and he ran away. He showed marked reading and mathematical retardation. He was given to constant enuresis and periodic soiling. He was unable to accept limitations. All in all, he had 13 symptoms.

Today, Harold is being prepared for care in a foster home. In that short time, he has gained sufficient internal integration to be able to behave acceptably in all his social relations.

If a qualitative change of this kind can be accomplished on a quantitative basis—that is, if such a change for the better can be brought about for more youngsters like Harold and if it holds under test—then, study and treatment homes will have won acceptance as a new tool in social work with disturbed children.

Reprints available in about 5 weeks

STATE ACTION FOR CHILDREN

SIGNIFICANT GAINS in behalf of children are shown by action of 1947 State legislatures. The following summary, though incomplete, covers proposals that benefit children which were included in the legislation recommendations sent to the States by the Council of State Governments for consideration in 1947. Several of these proposals are in line with recommendations made by the National Commission on Children and Youth in its action program of 1947 and 1948.

One of the recommendations of the Council of State Governments was that the official State crippled children's agency be held exclusively responsible for evaluating the need of a child for service under the State program and for determining whether a child is to be accepted for care. To this end, the council recommended that State laws requiring court action before a crippled child can be accepted for service under the State crippled children's program be repealed.

In its 1947 legislation, California eliminated its court action procedure. This action came as a climax of many years' effort.

Under the new law eligibility for care under the crippled children's program will be determined by the county agency designated by the county board of supervisors to administer the program for handicapped children.

By this action, California reduced to 12 the number of States that operate their crippled children's program with the court action procedure. Originally 14 States required such court action. Indiana eliminated this type of procedure about 8 years ago. The city of New York—but not the State of New York—dropped its court action for care of crippled children in 1945. Missouri has a bill pending that will be considered when the legislature reconvenes in January.

The 12 States still operating under legal requirements for court action are: Florida, Iowa, Kansas, Kentucky, Michigan, Missouri, New York (except New York City), Ohio, Oklahoma, Tennessee, Texas, and Wisconsin.

Revision of adoption laws

During the 1947 sessions of their State legislatures, two States—Arkansas and North Carolina—passed new adoption laws.

Fifteen States amended their adoption laws. They are: Connecticut, Florida, Iowa, Maryland, Michigan, Minnesota, Montana, Nevada, New Hampshire, North Dakota, Pennsylvania, Puerto Rico, Texas, Vermont, and Washington.

A preliminary review of the laws enacted indicates that many of the changes made were in accord with "Essentials for Adoption Law and Procedure" issued by the Children's Bureau and with the recommendations included in "Building the Future for Children and Youth" by the National Commission on Children in Wartime (1945).

More hospitals and better health as States get in line to benefit by the hospital survey and construction act.

16-year minimum age for employment

Child-labor bills were introduced in 14 States and in 11 of these States the bills called for a 16-year minimum age for employment or strengthened existing 16-year laws in line with the recommendation in "Building the Future for Children and Youth."

In its 1947 session, Alabama passed an act with a basic 16-year minimum age for employment, thereby becoming the eighteenth State having such a law. Also, Alabama reduced from 48 to 40 the number of hours a child under 16 may work each week.

In Missouri a child-labor bill setting a 16-year minimum age was introduced in the spring of 1947. This bill is still pending and is slated for consideration when the Missouri legislature continues its session in January 1948.

Two States in 1947 enacted laws raising minimum-age laws for general employment. Massachusetts set a 16-year minimum age for all employment in manufacturing and mechanical establishments by eliminating employment at 14 on special discretionary permits.

A new law was passed by Connecticut regulating the work of certain children in agriculture and also setting a minimum age of 14 years for work in agriculture outside school hours as well as during school hours. This State has long had a 16-year minimum age for most employment.

On June 30, 1947, the Illinois law, setting a basic minimum age of 16 years, became effective.

In preparation for its next session, the Maryland legislature provided for the appointment of a commission of 11 members to determine whether the child-labor law should be revised. This commission will report its findings to the Governor and Legislative Council by September 1, 1948, in preparation for the 1948 session.

In three States, protection against child labor was strengthened by passage of good compulsory school attendance laws. These States were Maryland, Michigan, and Tennessee. The acts passed eliminated or tightened exemptions under which children may leave school before they are 16 years of age.

To protect children, such as this girl, 18 States have child-labor laws with a basic 16-year minimum age for employment.

Hospital survey and construction act

Thirty-two States and Puerto Rico during 1947 passed legislation to enable them to carry out the programs pursuant to Public Law 725—the Federal Hospital Survey and Construction Act. Prior to 1947, 13 States, the District of Columbia, Alaska, and Hawaii had such enabling legislation.

In Arizona and Delaware, 1947 bills failed to pass.

Closely allied with this legislation are laws for State licensing of hospitals by State departments of health. Nine States and the District of Columbia had such laws prior to 1947. Twenty-three States and Alaska passed legislation in 1947. Two more States and Hawaii probably have adequate authority to license hospitals without additional legislation.

School lunch act

Based upon incomplete returns, 19 State legislatures took action in 1947 relative to provisions of the National School Lunch Act. Abstracts of action by States compiled by the U. S. Office of Education show:

Arizona provided for a nonprofit school-lunch program. (Ch. 98.)

Arkansas authorized the acceptance of Federal funds for the school-lunch program, provided for its administration by the State Board of Education, and authorized an appropriation of State funds to aid in the maintenance of said program. (Act 157.)

Colorado designated the State Superintendent of Education as the State agency to administer a school-lunch program in conjunction with the Federal Government, and made an appropriation therefor. (H. B. 44, enacted.)

Indiana authorized the State Superintendent to accept and disburse funds received from the Federal Government for use in connection with the school-lunch program, and appropriated $90,000 for its administration of said program. (Ch. 305.)

Iowa appropriated from general fund $8,000 to meet deficiencies in the school-lunch program. (S. B. 460, enacted.)

Kansas provided for the establishment, maintenance, operation, and expansion of nonprofit school-lunch program. (S. B. 102, enacted.)

Louisiana appropriated $300,000 for its free-lunch program. (H. B. 7, enacted.)

Maine provided for acceptance of the National School Lunch Act and set up the necessary legal authority for the State to accept such funds as are made available by the Federal Government and to administer the distribution and expenditure of those funds. (Ch. 127.)

Maine also passed a law requiring physical examination of all persons employed in school, including employees engaged in the preparation of school lunch. (Ch. 367.)

Mississippi appropriated $64,750 for defraying expenses incurred by the State department in the administration of the National School Lunch Act for the fiscal biennium beginning July 1, 1946 and ending June 30, 1948. (H. B. 71, 1947 extra session.) (Enacted.)

Mississippi also authorized acceptance of the provisions of the National School Lunch Act and designated the State Department of Education as the State agency for administration of the program. The State treasurer is designated as custodian of Federal funds. (H. B. 28, 1947 extra session.) (Enacted.)

Montana authorized the State Superintendent of Education to accept and administer Federal funds available under the Federal School Lunch Act, and appropriated from the common school equalization fund the sum of $20,000 for the biennium for administration of the said school-lunch program. (Ch. 282.)

Nevada provided for the establishment, maintenance, operation, and expansion of a nonprofit school-lunch program and the acceptance of the Federal School Lunch Act, and authorized a State appropriation of $18,500 for the biennium beginning July 1, 1947. (S. 100, enacted.)

New Mexico provided for the establishment, maintenance, and expansion of the school-lunch program and acceptance of the Federal School Lunch Act. The State Board of Education is to administer this program, and is given $17,000 per annum for the next biennium for its administration. (Ch. 98.)

North Carolina authorized a bond issue for buildings other than schoolhouses, including teacherages, garages, and *lunch rooms*. (H. B. 679, enacted.)

North Dakota made appropriation for administration of the school-lunch program in H. B. 46 and 47 (enacted). House Bill 48 (enacted) provided enabling legislation for acceptance of the provisions of the Federal School Lunch Act.

Oregon authorized the State Superintendent of Education to employ a director of the school-lunch program and to accept the funds available under the provisions of the Federal School Lunch Act. (H. B. 191, enacted.)

Pennsylvania provided for the establishment, maintenance and operation of nonprofit lunch programs. (H. B. 333, enacted.) House Bill 1343, Appropriation Bill (enacted) appropriated $90,000 for biennium for administration of school-lunch program.

Act 40 authorized all school districts to furnish food, including milk, to undernourished and poor school children.

Act 41 authorized nonprofit school-lunch programs in public schools.

Virginia appropriated $40,000 for the year 1946–47 and $40,000 for 1947–48 for its school-lunch program.

Washington authorized school directors of any district to establish, equip, and operate lunchrooms, provided the expenditures for food supplies shall not exceed the estimated revenue from the sale of the lunches, Federal lunch aid, Indian education fund lunch aid, other anticipated revenue to be received for that purpose by donation or otherwise, and cash balance during the preceding school year. (Ch. 31.)

Wyoming placed the administration of its school-lunch program in the State Department of Education. (Ch. 47.)

Enrichment of white flour and bread act

In 1947 Kansas and Oklahoma passed laws requiring the vitamin and mineral enrichment of white flour and white bread. Twenty-one States and two Territories now have such legislation. They are: Alabama, Arkansas, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maine, Mississippi, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Puerto Rico, South Carolina, South Dakota, Texas, Washington, West Virginia, and Wyoming.

Reprints available in about 5 weeks

Aware that a well-rounded lunch does much for health, 19 State legislatures took action on school-lunch programs.

New Bases for Eligibility in New York City Day-Care Centers

A child's own need, not the fact that his mother is employed, will be the basis of admission to public day-care centers in New York City under the new program of the Department of Welfare. This decision is in accord with the principle that the best type of care is in the child's own home. Children are to be accepted in the day-care centers only in those instances where it is impossible for them to be cared for properly at home, and only after consideration has been given to the possibilities of buttressing the home so that the child can be cared for there.

Determination of eligibility is to be made after study by the Department of Welfare to see whether admission to a day-care center would be in the best interests of the child. This will be done through a counselor attached to the center who will discuss the problem with the parent at the time application is made. A visit will be made to the home before a decision is made, with the help of the parent. Then, if the child is accepted, the counselor will maintain a close relationship between the center and the family.

Factors that will be taken into consideration will be the child's age, the amount and type of supervision he is receiving, and the total social and economic resources of the family, and in addition, what help other than the day-care service is available in the community. For instance, by drawing upon other services of the welfare department, or of other public and private agencies in the community, it may be possible for the child to be well cared for in his own home.

Heretofore, the day-care centers have accepted children primarily on the basis of the fact that their mothers were employed. The new program will not exclude the child of a working mother, but his need will be evaluated against other factors.

Three will be the minimum entrance age in the nursery groups. Two-year-olds will be eligible only in exceptional cases, a decision that is in line with the opinion of specialists that group living for such young children is by and large inadvisable.

Seventy-four of the ninety-four centers will be financed jointly by the city and the New York State Youth Commission, the remainder by the city alone. The Commission has allocated funds for a 3-month period of fact finding and experimentation. The centers it is helping to maintain are in high delinquency areas.

Harlan County Plans for Its Boys and Girls

AMBER ARTHUN WARBURTON,

Executive Secretary
Alliance for Guidance of Rural Youth

THE INSTITUTE

THE PEOPLE of Harlan County, Ky., met during the first week of September this year to find out what they could do to make their community a better place for growing boys and girls. The 4-day conference—called the Harlan County Guidance Institute—was sponsored by the county public schools and the Community Planning Council, in cooperation with the Alliance for Guidance of Rural Youth.

The institute was organized on the principle that the good community must be, above everything else, a democratic one, that it must be an organization in which each member is aware of his responsibility for the whole and contributes to the welfare of all. The institute itself was, therefore, democratic in this fundamental sense. The people of Harlan County came together to examine their own problems and work out their own solutions.

State and national leaders in many fields were invited to meet with the local people and help them with their advice and special information. These consultants represented Federal agencies concerned with children: State departments of education, health, and welfare, recreation, rehabilitation; the Federal Bureau of Investigation; the State university and teachers colleges; representatives of the State parent-teacher association, juvenile protection committee, Junior Red Cross, Save the Children Federation; the Alfred P. Sloan Foundation representative working with nutrition problems; director of the Louisville Mental Hygiene Clinic; director of the department of community service for the Committee for Kentucky; the National Education Association; Northwestern University; and Columbia University. The Harlan people were planning to attack their problem from every angle and they knew that the knowledge and resources of the State, region, and Federal Government would be needed if they were to do that effectively. But the experts were there as consultants, as one type of resource which any community can use in helping itself. They were not brought in as authorities who already knew the answers. As Dr. Dawson said in the opening address at the institute, "The job ahead is not one that can be accomplished in a few days; it will take months and years. It is not a job to be done by consultants from outside the county, but by all the people of the county themselves."

Plans were made for the institute early in June when school people and members of the Planning Council met with a representative of the Alliance for Guidance of Rural Youth to work out tentative goals. It was decided that the institute should help map out plans for programs on health and nutrition problems, educational and vocational guidance and child welfare, to aid in preventing juvenile delinquency.

Preinstitute planning in the local school areas was an important part in arranging for the institute. The superintendent of schools wrote to each principal of a county school urging that the school area select delegates to represent the community at the general sessions and discussion groups.

Late in August, a steady stream of news items began appearing in the county newspaper about the institute—what was going to be talked about, who was coming, local people who were helping with plans, school principals' and the parent-teacher association's part in finding people to attend the institute who would be responsible for follow-up action on recommendations. All over the county there was planning for and talk about the institute—who was going to give a visiting consultant shelter—transportation—entertain at a picnic supper at the Girl Scout Camp—arrange a trip to the Pine Mountain Settlement School or to coal-mining communities for the visitors to the county—or serve refreshments and introduce consultants at the social hour that was to conclude the first session. Preparations were under way. Harlan people were full of the institute.

The Friday before the institute convened the Youth Round Table, composed of two representatives from each of the eight high schools—met to choose their cochairmen—a boy and a girl—their recorders and a representative to speak for them at the first morning general session. In reviewing the program, they commented that it allowed for "endless talking" but conceded that that might be a good thing since if people in the community sat silent little or nothing was likely to happen by way of improvement. Therefore they were quite willing to sit through long hours of discussion in order to add their suggestions as they seemed pertinent.

On September 2 the institute opened.

Teaching good infant care to mothers is a first step in reducing infant mortality.

Most of the visiting consultants arrived in time for an afternoon meeting called at 3 o'clock for consultants, discussion leaders, and recorders to review the program and make last-minute changes. An hour before the opening session was to begin, the high, dark mountains that hem in the town of Harlan, the county seat, looked down on a steady procession that filed through the streets of the town to the high school. Out of the school busses that were making special trips to the far corners of the county poured teachers, parents, and representatives of the Youth Round Table. More than 800 people attended this meeting.

General morning and late afternoon sessions on key-note themes of the institute were held in the spacious gymnasium of the Evarts High School, located in the heart of a rural coal-mining community ten miles from the county seat.

Small groups met from 1:30 to 3:30 each afternoon to discuss problems and recommend action concerning educational guidance of children in all grade levels; remedial reading problems; vocational guidance; responsibility of the home in the development of the child; health; nutrition; recreation; and the place of art, music, and handcrafts in the curriculum.

Children are pretty much alike everywhere except as they are molded by their environment.

Mining camps usually provide a clinic that can be used in the school health program.

Several experiments were made in an effort to get wide audience participation in the general sessions. Perhaps the most effective procedure was one in which the problem for discussion was presented by the discussion leader with the help of the Harlan discussants who were seated at the table with him, and the "visiting experts" seated in a semicircle behind them. Here and there among the audience a person was asked to stand and those seated nearby requested to gather around him, direct their questions on the problem to him as he wrote them down. In a few minutes the audience again took their regular seats and the leaders of the small groups served as their spokesmen in presenting the questions to the discussion leader and the panel. Questions and answers came from the floor and the panel. The discussion was rapid and profitable. Everyone had a good time.

The illustrations accompanying this article are from the files of the U. S. Department of the Interior. They are not necessarily scenes from Harlan County, but illustrate problems discussed at the institute.

The Harlan Institute was sponsored by the county public schools and Planning Council with assistance from the Alliance for Guidance of Rural Youth. Any county interested in a similar institute should write to the Alliance at 1201 Sixteenth Street NW, Washington 6, D. C.

THE PROBLEMS

A survey made during the summer months preceding the institute, by one of the larger parent-teacher groups in the county, of what was happening to out-of-school youth in some of the mining camps scattered around the Evarts High School, was important in focusing attention on the problems that the institute would discuss. The survey was conducted as a house-to-house canvass by several parents. Questions were asked as to whether any child in the family between 6 and 18 years of age had been out of school during the past year, age of last school attendance, grade last attended, reason for leaving school, whether the boy or girl was at home or away, and what he or she was doing—employed, looking for work, or unemployed.

Ninety-five families were visited, and 36 boys and girls were found out of school. The parents who made the study realized that their findings had no statistical value, but they were very valuable in illustrating the kinds of problems that the institute needed to consider and the programs that would have most value in meeting them.

Illness was given as the reason why exactly one-third of the boys and girls were out of school. One 17-year-old said he had been sent home from school 3 or 4 years ago by the nurse because he had tuberculosis. Conditions in the homes visited led the people making the study—a housewife, a nurse, a barber, and a businessman—to see the need for a well-rounded school and community health program that would include physical examinations of the children, and health education in the classroom and community. They also felt the need for a school and community nutrition program that would include nutrition education and the serving of a hot lunch (and perhaps breakfast in some instances) to supplement the diet in the home.

Another important factor in poor school attendance was the indifference of the parents. This was especially true where girls were concerned. A great many boys had not attended school much beyond the primary grades but the parents felt somewhat more concerned about this than they did about the girls. Many of the younger children were out of school due to unsatisfactory bus transportation. Another problem which the study brought to light was that most of these children who were out of school were not constructively occupied. A few girls helped with the housework. One 16-year-old boy was working at a bathhouse. But otherwise they were unemployed.

The Youth Round Table made valuable contributions both in calling attention to particular problems and in suggesting remedies. In their preliminary meeting they asked assurance that such problems would be discussed as ways in which to improve teacher-student attitudes toward one another, methods of improving the physical conditions of the buildings and communities in which they attended school and lived, and methods of changing community attitudes so that they would welcome improved conditions and want to take part in achieving such ends.

The problems raised covered all phases of human life. There were special problems of teaching techniques and broad problems of juvenile delinquency. But in summarizing the findings most of these will fall roughly under the heads: health, nutrition, recreation, academic and vocational guidance, and parent-education.

THE RECOMMENDATIONS

The institute was set up to examine the problems facing the community and list the resources available for meeting them. It was a practical down-to-earth approach and brought to light a wealth of practical suggestions.

Health

For example, unusual facilities exist in the county for a school-health program, including medical examination of children. A physician is available in nearly all the mining camps who is already paid to give physical examinations to the children of miners. The Kentucky State Department of Education has passed a regulation requiring all schools to have organized a program within 2 years to give physical examinations to all school children. The division of maternal and child health of the State department of health has cooperated with the State department of education in drawing up a "Kentucky Health and Physical Education Code." The institute recommended that each teacher of the county be provided with a copy of this code; that services and facilities in the community be surveyed for giving children physical examinations; that examinations be as thorough as possible and be limited to the first grade, or to the first grade and as many other children as can be given satisfactory examinations and follow-up; that parents be urged to be present at these examinations and that the record of the examination be made available for use of the teacher in making guidance plans to meet the needs of the individual child.

It was also recommended that in-service training institutes for teachers in the county be held on school-health programs and ways in which findings of the physical examinations can be integrated in the school curriculum for the children; that the Harlan County Planning Council follow through on the suggestion that a mental-hygiene clinic be established; that further attention be given to health education in the school curriculum in the light of current policies and procedures; and—most important—that a representative school-health council be formed in each community and in the county as a whole.

Nutrition

The nutrition discussion group pointed out that the problem of poor nutrition was the same in Harlan County as elsewhere. It resulted from lack of knowledge regarding the importance of food to health and what constituted a good diet. Poor food habits and inability to buy proper foods were also contributing factors. While the people of Harlan County raised and preserved some of their own food, it was believed that diets could be greatly improved by better planned gardens and home preservation.

Recommendations from this group emphasized the need for a central nutritional committee for the county and similar committees in local school areas with membership including adequate representation from parent, teacher, and youth groups. Suggestions for the work of these committees should be furnished by the home economics teachers and supervisors, the home demonstration and agricultural extension agents, and public health workers.

Guidance

The Youth Round Table asked, among other things, for a counseling service in the high schools. They felt the need for counseling in: vocational guidance, college selection, boy-girl relationships, student-government problems, club activities, relationships in the home, and part-time employment.

The institute recommended that—

1. Special teachers should be assigned counseling work in each school, but all teachers should be given time to sit down and talk with their students.
2. An in-service training program in counseling techniques should be provided by the county superintendent of schools for teachers assigned specifically to guidance work and for all other teachers in the school system, as well.

Adult education

Many phases of adult education were considered such as the use of the radio to stimulate discussion on matters of community interest. But it was generally felt that the most important problem was to bring parents and teachers together. It was suggested that sometimes better response was achieved by calling the local parent-teacher meetings "get-togethers" rather than "teas" and that fathers could more often be included if it was understood that they were welcome without neckties and in their work clothes. In such meetings, it was felt, the problems of the teacher, the child, and the home would get franker and more sympathetic consideration, and the idea of cooperative planning by the home and the school be more likely to flourish.

A representative of the union to which many of the fathers of the school children belonged, recommended that the teachers come to meetings of the local union with their school problems, adding that the union might be in a position to help financially in meeting needs of the schools that could not be met by the county. The importance of the schools working with the union was stressed in the recommendation that the executive secretary of the follow-up committee for the institute arrange for a meeting with the union officials in Harlan County to explain the purpose of the institute and discuss ways in which the parents in the union could cooperate in planning and carrying out the health and nutrition programs, the vocational and educational-guidance programs, and plans for dealing with juvenile delinquency and for child welfare.

THE FOLLOW-UP

A committee was appointed to see that the recommendations of the institute are carried out. A series of radio programs has been arranged to keep the problems before the public and report on the progress being made. All recommendations will be followed up in county teachers' meetings and each teacher will be asked to report on how far he or she has been able to act on them.

In concluding the institute, the ability of the local people to work out solutions for their problems was stressed. It was pointed out that in these meetings the important things had been said by the local people in presenting their problems and in suggesting remedies. While it had been helpful to have consultants on call, the "experts" could not be expected to do the job—they could only give the "feeble shot in the arm of progress." The people must do the real work.

Reprints available in about 5 weeks

A sanitary home for every child is one guidance goal.

Meeting individual needs of children is difficult in crowded schools.

IN THE NEWS

United Nations Social Commission Urges Work In Child Welfare

The United Nations Social Commission met September 3, 4, 5, 8, and 9. It adopted a resolution recommending a preliminary program of work in the field of child welfare. It agreed to give priority to the organization of child and youth welfare services; to preparation of documentation on the Geneva Declaration with a view to its acceptance as the United Nations Charter of the Rights of the Child; and to principles underlying the treatment of family problems, including legislative measures and the desirability of international conventions on certain aspects such as family desertion, protection of the child against neglect and cruelty and punishment for such crimes, and the status and protection of destitute and stateless children. It adopted a resolution recognizing the permanent need for action to improve social conditions in underdeveloped and economically underprivileged areas and territories. It also set up a temporary committee for the coordination of social activities of the United Nations and the specialized agencies.

Source: United Nations Weekly Bulletin, September 16, 1947, p. 341.

Methods of Testing Vision of School Children to be Studied

What methods of vision testing should be used in school health programs? Who should carry out the tests—the teacher, the nurse, or a special technician? What findings as a result of these tests should be considered an indication for referring the child to a physician for complete examination?

To get answers to these questions, which are frequently asked by those responsible for school testing programs, a special study is being planned by the National Society for the Prevention of Blindness and the U. S. Children's Bureau, Social Security Administration, Federal Security Agency. Dr. William L. Benedict, chief ophthalmologist of the Mayo Clinic, Rochester, Minn., and secretary of the American Academy of Ophthalmologists and Otolaryngology, is chairman of an advisory committee of ophthalmologists that will furnish technical guidance.

The plan grew out of a meeting of educational authorities, physicians, school nurses, medical-social workers, and public-health authorities, at the Children's Bureau in Washington, June 6. It was called by the National Society for the Prevention of Blindness in cooperation with the Bureau. Dr. Franklin M. Foote, executive director of the National Society, presided.

The consensus of the conference was that the setting up of standards at this time was not warranted, for no one of the various methods now in use for visual testing had been sufficiently tested under controlled conditions. A special study was needed, the conference agreed, in order to evaluate the various procedures now in use or now being recommended for use in elementary schools. The Bureau and the society were asked to explore the possibilities of setting up such a study.

In addition to the study of methods, the conference also recommended that consideration be given the question as to whether the teacher, the nurse, or the special technician should conduct the tests. Such a study, it was pointed out, could only be carried out effectively with the cooperation of various community groups, including educators, physicians, and other health personnel, parents, and interested citizen groups.

Invited to the conference were representatives of the following agencies: American Academy of Pediatrics; American Association for Health, Physical Education and Recreation; American Association of Medical Social Workers; American Association of School Administrators; American Association of Teachers Colleges; American Medical Association; American Public Health Association; American Public Welfare Association; American School Health Association; American Teachers Association; Association of State and Territorial Health Authorities; Association for Childhood Education; Department of Classroom Teachers, National Education Association; Department of Elementary School Principals of the American Association for Health, Physical Education and Recreation; Joint Committee of the National Education Association and the American Medical Association; National Association for Nursery Education; National Council of Chief State School Officers; National Conference for Cooperation in Health Education; National Education Association; National Organization for Public Health Nursing; National Social Welfare Assembly; National Tuberculosis Association; School Health Bureau of the Metropolitan Life Insurance Company; School Health Section, American Public Health Association; Society of State Directors of Health and Physical Education; U. S. Office of Education; and U. S. Public Health Service.

North Carolina Measures Its Services for Children and Youth

Conditions affecting children and youth in North Carolina have been studied over a period of 3 years by the State planning board's committee on services for children and youth, and the committee has now reported on its studies in two publications. One, entitled, "What of the Children of North Carolina?" gives a complete report on the child population of the State in terms of number, race, and distribution by counties, on the economic resources of the State as they may be drawn upon for children's programs, and on the programs now operating. The second publication is an illustrated pamphlet, "North Carolina's Children," which is based on the main report. Planned as a guide for communities in studying local conditions affecting children and youth and finding out what services are available to them, it tells of the long-range needs of the children of the State and describes the continuous planning by the State and the community that must be done if the welfare of the children is to be safeguarded.

Dr. I. G. Greer, superintendent of Mills Home, Thomasville, is chairman of the committee.

Stella Scurlock

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"Let us not deceive ourselves: The power to maintain a decent family living standard is the primary essential of child welfare. This means a living wage and wholesome working life for the man, a good and skillful mother at home to keep the house and comfort all within it. Society can afford no less and can afford no exception. This is a universal need."

Julia C. Lathrop

• FOR YOUR BOOKSHELF

MATERNAL AND INFANT MORTALITY IN 1944. U. S. Children's Bureau Statistical Series. No. 1. Washington, 1947. 17 pp. Single copies free.

This is the first of a new Statistical Series, which takes the place of the Social Statistics Supplement to THE CHILD. The bulletins in this series present analyses of periodic data useful to research, administrative, and informational specialists in the field of services for children. In these bulletins from time to time will appear data on the operations of public health and welfare programs, statistics on conditions of child life, and related source materials. The series title serves as a connecting link to help readers keep their files of this reference material intact. If you would like to receive notice of publication of bulletins in this series, send to the U. S. Children's Bureau a request that your name be placed on its mailing list: Specify list SS–1 if you want notice of all issues, list SS–2 if you want notice of health issues only, or list SS–3 if you want notice of welfare issues only. Additional copies of individual bulletins may be purchased from the U. S. Government Printing Office.

HELPING CHILDREN IN TROUBLE. Publication 320, U. S. Children's Bureau, Washington, 1947. 17 pp. Single copies free.

An account of the Children's Bureau "experiment in child welfare," which was described in THE CHILD for October 1946. A full report of the work has been published under the title, "Children in the Community; the St. Paul experiment in child welfare" (Children's Bureau Pub. 317, Washington, 1946).

MOTHERS FOR A DAY; the care of children in families other than their own, by Bessie E. Trout and Dorothy E. Bradbury. Publication 318, U. S. Children's Bureau, Washington, 1946. 39 pp. Single copies free.

Daytime care in a family is only one of several ways in which the problem of caring for children while their mother is at work can be met, says this bulletin. Because community services to children must include care for children of different age groups and with different family situations and needs, a variety of types of care must be planned. Homemaker services may be used for the child in his own home; group care such as the day nursery, the nursery school, and extended school programs for children who can benefit from group living; family day care for the very young child and for those children for whom this type of care is most suitable. Counseling service is also needed to help parents make the best use of all the services offered. A community program for day-care services, therefore, should include provision for many different types of services in order to meet a wide range of individual needs.

The Children's Bureau has had many requests for assistance from communities and agencies that are developing or wish to develop a family day-care program. This pamphlet is an attempt to bring together some of the experiences and practices of agencies providing family day-care services in the hope that it may be of help to those developing programs and may stimulate others to contribute to this relatively new field of child care.

SO YOU'RE EXPECTING A BABY. Folder No. 1, revised 1947. U. S. Children's Bureau, Washington, 1947. 29 pp. Single copies free.

It is nearly a quarter of a century since the Children's Bureau first published its Folder No. 1, for the busy mother who could not take time to study the Bureau's more complete bulletin, "Prenatal Care," but who wanted help in getting ready for the birth of her baby.

Since 1923, when the folder was first published, with the title, "Minimum Standards for Prenatal Care" and the subtitle, "The Least a Mother Should Do Before Her Baby Is Born," it has been frequently brought up to date to keep up with advances in medical knowledge. But only once before has it undergone a complete revision, with a change in title. That was in 1936, when it appeared under the title, "The Expectant Mother."

The 1947 edition is a booklet rather than a folder. And something new has been added in the way of color and illustrations. A few of the section headings are: "When shall I go to the doctor?" "How shall I choose him?" "How can I be sure I'm pregnant?" and "When shall I expect the baby?"

The pensive little girl on this month's cover was photographed for the U. S. Children's Bureau by Esther Bubley.

Credit for other photographs:

Pages 66 and 68, Esther Bubley for U. S. Children's Bureau.
Page 71, U. S. Public Health Service.
Page 72, U. S. Children's Bureau.
Page 73, U. S. Department of Agriculture.

• REPRINTS AVAILABLE

A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had without charge.

An Integrated Approach to Cerebral Palsy. By Eunice Usher. *Delaware State Medical Journal*, September 1946.

Convalescent Care of Children. By Ethel L. Dill, R. N., and Isabelle M. Jordan, R. N. *American Journal of Nursing*, December 1945.

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• CALENDAR

Nov. 3—Second General Conference of UNESCO. Mexico City.

Nov. 28–30—National Council on Family Relations. New York, N. Y.

Dec. 1–4—The Association of State and Territorial Health Officers, Washington, D. C.

Dec. 3–7—American Public Welfare Association. Cleveland, Ohio.

Dec. 8–11—American Academy of Pediatrics. Dallas, Tex.

Ten Young Men From Burma

The other day the Children's Bureau had the great privilege of receiving an extraordinary group of foreign visitors, ten young men from Burma. Six of these young men are Senators-elect, to take office in January in the first Congress of the newly constituted republic of Burma. They are in this country now as the first official mission sent to foreign countries by the Burmese Government to find out from us about our ways of dealing with many social problems, especially as they relate to children and young people. They came to the Children's Bureau, as their leader, Mr. Kyaw Myint stated it, to learn our methods of getting care to mothers and children.

Their youth and their earnestness made the meeting with them memorable. They seemed fully aware of the great responsibility that had fallen to their lot, and fully appreciative of the great difficulties that lie ahead. They had the confidence of men who know what they intended doing and were losing no opportunity to prepare themselves for the task.

They took many notes, as I tried to explain to them in the short time we had together, how the Children's Bureau was brought into being, what it stood for, and how it had grown and developed through the years. I described the operation of our State and local maternal and child health and child welfare programs and the responsibility the Federal Government has in aiding their development.

They asked pointed questions, and then, in their turn, they told something of the problem they face in Burma. The infant mortality rate, they told us, was around 250 deaths for every 1,000 live births and maternal mortality rates were likewise high. The difficulties of getting care to Burma's mothers and children are enormous, they pointed out, because of the undeveloped condition of so much of the country and the isolation in which so many of the people live. Yet they were undaunted: they would begin where the people were, Mr. Myint explained, that is, in the villages and work from there. They would appreciate whatever advice and help we could give them, and for our part, we of course, would consider it a privilege to help.

I was impressed by many things as we talked together, the sense of history being one of them. These young men were taking over responsibilities of governing one of the oldest countries in the world and the form that government was taking was our own, a republic. Our own people, our own young men, had once undertaken as grave a responsibility. Jefferson, I remembered, was only thirty-three when he wrote the Declaration of Independence, and many of those others whom we now venerate, I realized, must have been just such young men as these.

Here was something in which to take hope in this present hour of discouragement—ten young men from Burma set out prior to taking high office in order to find out how governments could bring health and welfare services to the people. I was proud to be able to tell them about the work of the Children's Bureau, and about the work carried on by State and local agencies and other groups working in this country in behalf of children, and I was especially proud that they had chosen to visit the Children's Bureau. Most important, though, I was impressed with how very much we, in one of the oldest republics, have in common with those of the world's newest republic, for our approach was the same, that is how, through government the welfare of the people might be bettered. The phrase the Burmese used to say the same thing is that the efforts of the new government would be directed to improving the Nation's "man-power," and to that end improving the situation of the children was a most pressing need.

Katharine F. Lenroot

KATHARINE F. LENROOT
Chief, U. S. Children's Bureau

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Katharine F. Lenroot, Chief

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THE CHILD

DECEMBER 19

WHEN A SCHOOL CHILD IS IN TROUBLE

School Social Worker Joins Hands With Teacher in Solving Children's Problems

ALMA LAABS, Senior Consultant in School Social Work, Minneapolis Public Schools

BASIC to the content of the social case work program in the schools today is the role, the philosophy, and the practice of education. Now as never before we are forced to evaluate the responsibility of the schools for helping to develop youth who can live in and build a truly democratic society in the United States and in the world.

The school sees large numbers of children of school age. It sees them for 5 or 6 hours a day, for 10 months of each year for 8 to 12 years. Consequently what happens to the child in school is a vital and tremendously important factor in his growth and development, in his adjustment or maladjustment.

Social work in the schools, or as it was formerly called, visiting-teacher service, is profoundly influenced by the philosophy of education as a whole concerning the function of the school, the school's responsibility for all children, its position and standing in the community, and, particularly, by the attitude of the school administration toward social work itself.

A dynamic philosophy of education

Many schools today have a concept of their responsibility and their role which seems invigorating and broad, and which gives great hope for the future of youth. Such publications as the Educational Policies Commission report, Education for All American Youth, and the Harvard Committee's report, General Education in a Free Society, and Dr. Daniel A. Prescott's report for the American Council on Education, Helping Teachers Understand Children present a philosophy of education that is both dynamic and vital.

Here are excerpts from a statement tentatively proposed by the Minneapolis Public Schools to show the objectives of education:

Education in Minneapolis today has a twofold responsibility, to society and to the individual. The responsibility of our schools includes adults as well as school-age pupils. . . .

The responsibility of education to society is that of preserving and extending democracy, preserving and rebuilding human and natural resources, and developing world relationships and understandings.

. . . . . .

Education must be concerned with the conservation of human resources. Since the people of a nation are its most important asset, we believe America must find a way to make it possible for each school-age youth to have an opportunity for securing the education he needs to meet his responsibilities as a useful citizen of society.

. . . . . .

We must provide ways of developing special abilities so that each child has the opportunity of realizing his potentialities.

. . . . . .

We believe the responsibility of education to the larger society of world relationships requires the development of an understanding that the world is a community of nations.

. . . . . .

Education must help develop an understanding that the differences of the peoples of the world are largely cultural differences.

. . . . . .

The responsibility of education to the individual must take into consideration his physical welfare, his emotional stability, the information and skills he needs, his economic competence, and his attitudes and beliefs.

. . . . . .

The total program of the school must consider the total development of each pupil.

. . . . . .

Education has the responsibility of contributing to the emotional growth and stability of each pupil. This may be accomplished by a concern for the chance each pupil has to contribute to his group, by providing acceptance and understanding, by considering maturity levels, and by relieving pressures.

. . . . . .

We believe education has the responsibility of helping pupils acquire the information and skills demanded of them for adequacy in the modern world. This adequacy will demand a knowledge of the cultural heritage, ability to think critically, proficiency in skills, worthy use of leisure time, and a zest for learning.

. . . . . .

We believe education should equip every individual to be an intelligent producer and consumer.

Education must be concerned with what an individual believes, how he feels toward people and things. The individual should place high value on human relationships, home life, and appreciations of the beautiful. He should assume responsibility for the direction of his own life.

Such a concept of education is tremendously challenging. To achieve these objectives we know that many changes will have to be made in the day by day way schools are run, in the curriculum which is offered, in the attitudes of school personnel, and in the actual use of school buildings.

The content of school social work

The school social worker is part of the educational personnel. She is not an outsider, a frill, or a fad. She is a member of the school staff who differs from other school persons only in function and in training. Just as the school doctor and the school nurse relate the field of health to education, so the school social worker brings social-work concepts and philosophy into education. She implements and complements the program of the entire school.

The role, the function, and the practice of the school social worker are affected not only by the philosophy of

ucation as a whole, but by a number of her factors:

1. The schools have a concern and a sponsibility for all children who are attendance. Although they are inter- ted in the individual child, they see m primarily as a member of a group, terms of the effect of his behavior on e group, and what they can do for him a member of the group. The help ey can give him as an individual is de- rmined—and in some instances, lim- ed—by the needs of all children in the hool and the responsibility the school as for them.

2. The schools have a legal responsi- ility for school attendance. To the hool board, the superintendent, and, turn, the principal is delegated the esponsibility for enforcing the law re- ting to school attendance.

3. The schools must meet certain ressures; for example, pressures grow- ng out of the size of class load. The chools cannot refuse to admit children ven though the school is overcrowded. ther pressures grow out of the child's rogress from one grade to another. At he present time, the school term is usu- lly 9 or 10 months; and at the end of hat time the school must make a decision as to a child's promotion to another grade, must judge his progress.

In many places there is a prescribed ourse of study, issued by the State or by the central office in the local community. Teachers and other school people are under pressure to cover the material recommended in this course of study for a particular grade in a certain given time. Also the community and the parents put on the school both a responsibility and limitation as to what it can do for the children. A change of curriculum or methods of instruction must have the backing of the community and the parents before it is effective. Because of all these pressures, such things as regular school attendance, progress in achievement, the time necessary for adjustment of the child's behavior become all-important issues to the school personnel, sometimes to the exclusion of other issues.

4. The individual philosophy of the school personnel as to the school's role or the objectives of education will determine their relationship with the school social worker. Is it liberal, broad, dynamic? What does the teacher see her role to be with each child and with the group? Can she use other resources to complement her own? Is she interested in causative factors or only in present behavior? Can the teacher see behavior apart from herself? These points will be influenced by her training and by her feeling of her own standing as a teacher in the school system and in the community.

Happy, interested school life contributes greatly to a child's normal emotional development.

5. This brings us to still another factor that influences the work of the school social worker, the training and selection of teachers. As a whole, teacher-training courses have included little emphasis on child development or human behavior. In their training, teachers have received little help in seeing the child's behavior in relation to themselves or much understanding of their own needs and behavior. Today some schools of education are emphasizing this area in the training of teachers—but in the past and for many teachers on present school staffs knowledge of child development and behavior is very inadequate.

Very often teachers have little insight into their own or the child's behavior. Here again the school social worker must complement and extend the knowledge of the teacher. Unfortunately, too, little emphasis has been placed on the selection of teachers in terms of their emotional stability or their basic relationship with other human beings.

6. The community demands a certain standard of behavior from school personnel, especially in the smaller communities. Often school people resent the limitations on their personal behavior or way of living imposed upon them by the community. Teachers need an active part in the community life if they are to perform their function in the development of children as we should like to have them do. They must be citizens as well as teachers. Only in this way can they grow to feel that they are making a vital contribution to the community.

Then too, there is the whole question of salaries. We are all aware that the salaries of teachers are too low. Because teachers are paid so inadequately we are not able to hold the kind of personnel we want in our schools. All these factors make the adjustment of the teacher difficult—and her lack of adjustment is often reflected in the adjustment of children to the school.

7. There are certain feelings and attitudes between workers in education and in social work which handicap individuals in both fields. Education is an old, established profession. There are many precedents from the past. Educators have been working with children for many years. They feel that they must be responsible for a group of children and for the good of the group.

Social work is a newer profession. Its

Condensed from paper given at the National Conference of Social Work, held April 13–19, 1947, at San Francisco.

Some underlying problem may be the cause of a child's not getting along with his schoolmates. When the school social worker is consulted she will try to get at the root of the trouble.

main emphasis is on development of and help to the individual. It has an orientation in the field of human behavior. Often educators feel threatened by the ideas of these new members of the school staff—the school social workers. In general, school personnel have not been orientated in the field of community resources or the policies and functions of social agencies. On the other hand, social workers often do not understand the schools of today or the philosophy on which they function. Each group, social workers and educators, finds the terminology of the other difficult to understand.

The tempo of the work of the two groups is different, too. The schools must get certain things done because of the pressures of time and schedules, while the very basis of social work is to give help to the individual, not on a time schedule, but as he can change, or as he can use help. Educators often question some of our social-work practices; for instance, limitation of intake, and closing of cases if the family cannot use treatment. Schools must take all the children.

8. The school principal is the administrative head of the school, which social workers should always remember when they are working with the schools. In addition to the principal and the teachers there are other school personnel who have a common relationship with the child—the nurse, the counselor, and so forth. All these must be considered in any planning for the child.

9. Finally, the school social worker must frankly and realistically evaluate her own attitudes toward the school and its work. They will affect her relationship to the child, to the school, to the parent. How does she feel about the school's procedures and philosophy? Although she need not approve the school's procedures or philosophy in detail, she must objectively evaluate what she can do in the school situation to help both the child and the school.

The functions of the school social worker

With these factors in mind, what are the functions of social work in school and how do these functions affect its practice?

First, the functions of the school social worker are:

1. To help the individual child find a personally satisfying and socially effective place in the school and in the community.

2. To consider and plan with the teacher and other school personnel how and to what extent the needs of the particular child can best be met in the classroom and in the entire school program.

3. To help parents understand the purpose and the program of the school; to assist the parents through their relationships with the child to facilitate his best use of the school; to promote understanding and acceptance between the parents and the school.

4. To procure the services of other social agencies in the community in assisting the child and his family; to promote understanding of the purpose and the program of the school among representatives of social agencies.

5. To stimulate the school and the community to recognize a responsibility to children for adequate facilities in education and other welfare services as needs become apparent from the school social worker's experience with individual children who are unable to make effective use of the school or whom the school is not able to help effectively because of lack of resources.

In the main, children are referred by the principal or the teacher. What children will be referred, the manner in which they will be referred, and when, will all be determined by the various factors affecting the role, function, and practice of social work in the school. If the school sees the services of the social worker as a part of, or as complementing, the school's work with the child, it will mean that the teacher or the principal will ask for the assistance of the school social worker early in the development of the child's behavior or early in his school experience. This attitude will strengthen and clarify the relationship during the period of study and during treatment. However, if the school feels resistant to the child and his behavior, or feels a need to punish the child or to have him made over; or if it waits until the situation is an emergency one, or uses referral as a threat to the child or the parent, the school social worker will be limited in what she is able to do.

The very introduction by the principal or the teacher of the social worker to the child or parent will affect her role and what she is able to do. If the principal can introduce the social worker to the parent and the child as someone who is able to help because of her particular skills; if the principal or teacher can see herself as a factor in the behavior, in the progress, or in the attendance of the child and also see herself as a person who can assist both the school and the school social worker, there can be a great deal of strength in the referral by the school of the child and his parents to the worker. In the ajority of cases the parent and the hild are willing to accept the problem t school whether they agree with the chool or not. They can see there is a roblem. The school social worker is here the behavior takes place; and ften, for this very reason, she is able to elp the child and the parent to focus n the problem and to grow in their nderstanding of it.

ehavior symptomatic of other difficulties

We know that the behavior at school, e it incorrigibility, inability to get long with other children, resistance to chool routines, nonattendance, or nonchievement, are symptoms of more asic difficulties. His adjustment at chool is a vital part of the child's overll growth and development, and as we ave said, parents and children as a rule an accept the problem that is there. I vant to say again that the fact that the school social worker is in the school vhere the child is, where his behavior s taking place, is a dynamic factor in reatment. The school social worker nd the school know this behavior has aken place. The child knows they now. The child and the school social vorker can meet on a basis of this knowledge. The same is true of the parent.

We need to mention at this point too that if authority has to be used to help he child and the parent to focus on the problem, the school has authority in regard to behavior at school and in regard to attendance at school.

Because all children are at school and the school usually has many children, there is going to be pressure in terms of the number of children that the school will want to refer. The school social worker is accessible to the broadest possible intake and therefore is going to be subjected to pressure in terms of the number of cases she can carry. Is she going to take all the cases that the school may want to refer? How can she control the intake and still make the school feel that she is giving the help it needs? Then during treatment or during the period of study, there will be pressure from the school because the school sees this child every day as he comes to school clean or dirty, unhappy or content, successful or unable to achieve. The school will want to see something being done.

Home difficulties seem to be interfering with Wilbert's success in school. But his teacher knows that she can call on the school social worker for help in solving these difficulties.

In the treatment situation, the school social worker must always keep in mind that there is a two-fold relationship involved. She has a responsibility to the child and to the parent to help them with their individual problems and needs. She also has a responsibility to help the school.

In treatment she must assess the relationship of the teacher, who is the pivotal person, and the child. The teacher sees the child daily. She can help him in his group contacts. She can also help him through her own relationship with him and with his need for achievement. The social worker, through her technical skills in case work, can help the teacher to estimate the child's adjustment and make her best contribution to it.

The school social worker must give thought and consideration to the exchange of information with the teacher about the child's problem or the parents' background. Teachers often report that social workers do not give them essential information about the child. Often, they say, social workers leave them in the dark about the problems they discover.

Social workers, on the other hand, feel that certain information could not be given to the teacher without violating the confidence of the parent or the child. A social worker, of course, is forced to keep in mind the confidential nature of the client-worker relationship, but it is part of her job to find ways to give the essence of this information to the teacher. Having been given a better understanding of the child, the teacher can then help the child more skillfully, more successfully.

The relationship between the teacher and the child, and even the consideration given to it by the school social worker, is influenced by the teacher's philosophy, by her training, by her emotional balance. There will always be some teachers who feel threatened by the relationship of the social worker to the child. They will be unable to see that there is a difference in the relationship of the social worker and her own relationship to the child. As the social worker makes recommendations as to the needs of the child, she also must keep in mind the classroom situation of which the child is a part, the make-up of the class, the achievement level of the child and the class, the general behavior of the entire group of children.

In her relationship to the child or to the parent, the school social worker needs to make clear her responsibility to the school. The child needs to know that there are certain things the social worker must talk over with the teacher. The worker can help the child make decisions or meet his responsibilities, but there are certain decisions she cannot make and certain difficulties she cannot get him out of. The same thing is true of parents.

The social worker also has a relationship to the teacher quite apart from her relationship to the individual child. She needs to assess her own feelings about the teacher because these feelings will influence her work with the individual child and his problems. This will also affect her ability to help the child in his contacts with the teacher.

On the other hand, the teacher may feel that she has not been effective in her work with this child. She may feel threatened by the social worker as a person and as a member of a different profession.

A social worker's too frequent use of social-work terminology outside her professional circle is a disadvantage. A social worker should use plain, ordinary English in explaining her work to others. With teachers she should use technical terms only when they are common to education and social work.

Often teachers resent the apparent freedom of the social worker in the matter of being at one place at a certain time, her freedom concerning her time.

Because the school social worker is a part of the school, she can call upon school resources available in the treatment of the child's difficulties; for instance, the whole field of special education; the various special activities in the school such as dramatics, music, art, home economics, vocational education. All of these can be used to help the child according to his needs and ability to use them. The school social worker can work out with the school the use of these particular facilities. In some instances a shift in curriculum may be used for the growth of the child.

The use of school resources in curriculum, special assistance in achievement, or training in particular schools, help with the child's adjustment in the group, are all very pertinent and sometimes are the only way we can help the child. Along with the material resources in the school, there are various school personnel who can give assistance to the child or can be drawn in to help the child; for example, the school counselor, the school nurse, the psychologist, and possibly the psychiatrist.

Perhaps in many instances we cannot change the home situation or we cannot basically change the parent-child relationship, but we can help the child in the normal relationships which are a part of his school life. Sometimes we cannot do much in working with the basic problems, but through the teacher-child relationship the child can gain certain satisfactions.

Perhaps at the point of referral to the school social worker, this need for the use of other community resources is evident. There may be an agency already active in the case. By thinking through with the parent and the child the possible use of agency services, often the problem at school can be discussed with the agency and the treatment focused in this agency. Under such circumstances, the school social worker continues in the liaison position between the school and the agency so that there can be an exchange of experience and information between the agency and the school. If an agency is not active, the school social worker is in a position to think through with the parent and the child the problem as presented and the use of other community resources in the solution of it. She may confer with the other social agencies as to their ability to take on the situation, and in turn she may interpret to the child and the parent and to the school the services available through the agency.

School social worker as consultant

Thus, the school social worker serves as a liaison person between other agencies and the school. She can get information for them. She has an opportunity of conferring with the school personnel who see the child in these various relationships. This information can be very helpful to the social worker in the other agency.

Besides her work with the individual child, there are other equally important functions of the school social worker; for instance, often she is consulted by individual teachers, not about the particular child, but about children's behavior in general or about the problems she, the teacher, meets in her classroom. The school social worker can give information about the community and the community resources.

Her work with individual children, her training with special orientation in the field of child behavior and child growth, should be made available to groups concerned with the over-all curriculum in the schools or over-all school practices. In some communities, the school social worker or the school psychologist or school psychiatrist serves on curriculum committees or on committees concerned with school practices in general.

In certain communities the school social worker serves as a discussion leader with parent groups or she is called on to meet with these groups. These discussion groups are one of the newer developments in education. Many schools realize that part of their objectives can be achieved only through a better relationship with parents. The schools should be offering opportunities to the parents of the children to become better acquainted with the school. Increasingly schools are becoming community centers. Many school systems are using parent-teacher conferences instead of report cards. Out of these conferences come requests for discussion groups about children's problems.

Finally, the school social worker has an opportunity and a responsibility of interpreting the function of the school and its policies to other community social agencies, and vice versa. Neither the schools nor the social agencies can meet the needs of children alone. They must work together. Each must correlate its activities with the activities of others. If there are certain adequacies in our present program, these must be met together. Too often we criticize each other and do nothing in a positive or constructive way to assist in making the services available to children more effective or more adequate.

At the present time, in many places the school social worker must work without supervision. As yet schools have not seen the need for case consultants or case supervisors to the extent that they are used by social agencies. In the majority of school social-work staffs, the supervisor of the staff has both administrative and consultative responsibilities. In some places, this one person is responsible for a staff of from 20 to 30 people. Thus, the school social worker is forced to work independently. And therefore she needs to be a mature person with confidence in her own skills and in her relationship to the whole field of education.

Reprints available in about 5 weeks.

NEW ZEALAND CARES FOR CHILDREN'S TEETH

EARLY THIS YEAR New Zealand's Department of Health began to provide free dental services for adolescents. This is the second phase of a national dental program, the first phase of which began more than a quarter of a century ago, when provision of dental services began for children of preschool age and for those in primary schools.

Under the new phase of the program, adolescents who have been receiving regular dental service during their school years, either from the school dental service or from a private dentist, are eligible to continue to receive dental care, paid for by the Government. Only adolescents whose oral fitness is up to a certain standard are eligible for this care, as provision for minor treatment only is intended.

Pending the development of a staff of full-time salaried dentists, which is planned for the future, the Government pays private dental practitioners for the care of these adolescents on a fixed-fee-for-service basis. This plan has the approval of New Zealand's dental profession.

For the present the upper age limit for this service is the child's sixteenth birthday, but as more dentists become available the Government expects to raise this limit to the nineteenth birthday. Two-thirds of the children now eligible are enrolled.

The free care provided by the school dental service to primary-school children and to preschool children over 2½ years of age is unique in that it is given by dental nurses. When the plan for dental nurses was first made by the Government, in 1921, it was considered a radical move, but the New Zealand Dental Association formally approved the proposal, and soon afterward the first group of young women began the required 2 years of training. They completed their training in 1923, and then the plan went into action. Each year since, as more and more dental nurses have been trained, new school dental clinics have gone into operation.

The dental nurses do not do everything that a dental surgeon does. The treatment given by dental nurses includes fillings in both deciduous and permanent teeth, extractions (using local anesthetics only), and prophylaxis. No root treatment is undertaken. The "sealing off" of susceptible pits and fissures—known as prophylatic odontotomy—is extensively practiced.

Dental nurses do not attend children over 15 years of age.

The director of the dental-hygiene division of the Dominion Health Department (himself a dental surgeon) is in charge of the school service, which has six units. Each unit is controlled by a senior dental officer, who is directly responsible to the director. These six officers include the principal of the Dominion training school for dental nurses, and each of the five principal dental officers, who are in charge of the five dental districts into which the Dominion is organized. Each of these districts has about 80 dental nurses.

The principal of the training school is responsible for the training of the school dental nurses, and also for the operation, as a public institution, of the children's dental clinic, which is a part of the training school. Normally about 200 student dental nurses are in training at one time. They enroll in groups of 50, at intervals of 6 months.

Applicants for training agree to serve for 3 years after graduation, in any part of the country. They must be over 17 years of age, and preference is given to those between 18 and 25. Each must meet certain physical and educational requirements.

After graduation the nurse works in a clinic attached to a primary school. Although actually under the direct control of the principal district dental officer and his staff, each nurse is virtually a member of the school staff. Her task is to keep about 500 children in good dental health. In addition, she instructs the children in oral hygiene and preservation of teeth.

According to the annual report of the dental-hygiene division, issued in September 1946, approximately 200,000 children, in more than 2,000 schools, received regular dental care, an increase of 10 percent over the year before. Of these, 24,364 were of preschool age.

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TO STRENGTHEN FAMILY LIFE

EDITH ROCKWOOD, *Office of the Chief, U. S. Children's Bureau*
Member of Technical Advisory Committee, National Conference on Family Life

WHAT ARE the forces working for and against the family in these days of rapid and bewildering change? What can community and educational resources do to strengthen the family? These are some of the questions that people are asking and that have led to the planning of the National Conference on Family Life, which will be held at Washington, May 6–8, 1948.

More than 110 national organizations are jointly sponsoring the conference. These organizations have a wide range of interests. They include parents, home economists, doctors, nurses, dentists, social workers, teachers, and clergymen, as well as representatives of such fields as housing, vocational guidance, recreation, organized labor, industry, and agriculture.

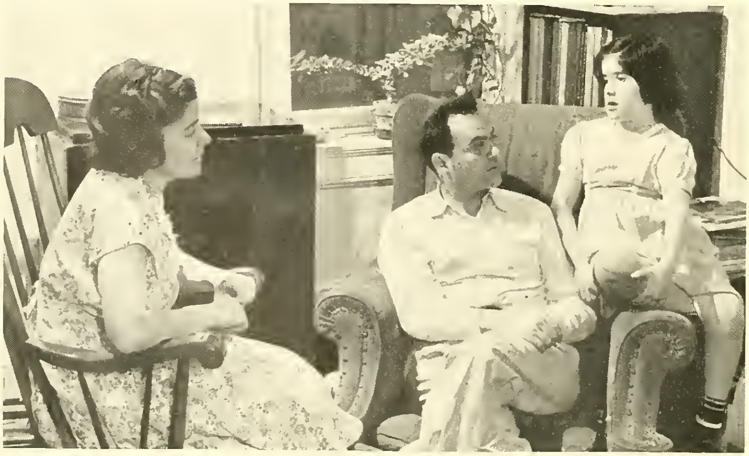
President Truman has expressed his "wholehearted concurrence in the objectives of the proposal," and in a letter to the vice chairman says, "I shall be glad to extend to such a conference as you are planning the courtesy of the White House as a place of meeting, as evidence of my official and personal interest."

Those preparing for the conference are assembling factual material as background for the discussions. This includes such data as where families are living, what is their cultural background, how many children have been born to them, how many have married sons or daughters. Data on income will be collected, including not only the amount, but on who is responsible for the family support, and whether the mother is a wage earner. Study will be made of families as consumers and on the adequacy of their standards of living. Material on the legal status of families will also be collected.

Information will be assembled on families as social groups and the family-life cycle. This cycle begins with the premarriage period — courtship and mate selection. It goes on to early marriage adjustments, up to the conception of the first child. Parent-child relationships come next—among families with young children and families with older children. Then come the middle years, when children mature and move out of the parents' home. And last is the stage of the empty nest.

The experience of families during critical periods will be reviewed, such as when a new baby is born or some member of the family dies; also causes of family conflicts, especially those resulting in divorce or separation.

Secure, wholesome family life will build a firm foundation for the strength of the people.



Under the guidance of a technical advisory committee of some 75 members, 10 committees are developing reports on problems and issues that confront families. Each of these committees will cover a subject important in family life; the subjects are: home management, housing, economic welfare, education, health, social welfare, community participation, legal relationships, counseling and guidance, and recreation.

Representatives of Federal agencies are included among the members of the technical advisory committee.

The chairman of the board of trustees of the conference is Eric A. Johnston, president of the Motion Picture Association of America. The vice chairman is Boris Shishkin, economist, of the American Federation of Labor. Frank J. Hertel, director of the Family Service Association of America, is treasurer. Dr. Ernest G. Osborne, professor of education, Teachers College, Columbia University, is program coordinator and chairman of the technical advisory committee. Dr. Alexander Radomski is Washington representative. Mrs. C. H. L. Pennock is the administrative secretary. The conference is incorporated. Its administrative offices are at 10 East Fortieth Street, New York 16, N. Y.

The board of trustees is made up of 40 members, broadly representative of civic, religious, farm, business, labor, and professional groups.

The proposal for such a conference first came from the American Home Economics Association in 1944. The National Planning Association and the Woman's Foundation assisted in the process of organization. By June 1946 preparation for the conference had begun.

The purpose of the family-life conference is to find specific ways, in a great variety of fields, in which the family can be strengthened and made more secure. The conference will take stock of the family in the modern postwar world. It will develop guideposts for programs of action which will help achieve greater security for the family and all of its members, including mental and emotional as well as physical and economic security.

SOCIAL WORKER PLAYS PART IN COURT PROCESS

WARRINGTON STOKES, *Administrator, Multnomah County Public Welfare Commission, Portland, Oreg.*

ONE of the most significant developments of our century in the administration of justice has been the growing realization that justice must be tempered, not only with mercy, but with a knowledge of human behavior and of the relationship of the individual to his family and society.

We are no longer satisfied to believe that punishment, or the admonition to "go and sin no more" will result in redemption. For reasons that are readily apparent this development has been most marked and has made the most headway in those courts having jurisdiction over juveniles, although it is becoming increasingly evident in courts dealing with adult offenders.

However, many of us whose experience has been in the larger centers of population, where courts have developed the most comprehensive services, tend to forget that throughout the country there are communities that have not yet seen the advantages of providing the knowledge and skill contained in the field of social work as an adjunct to the more legalistic functions of the court.

Since the problem of the offender, both juvenile and adult, is becoming increasingly important in our complex civilization, it is imperative that we give careful consideration to defining and clarifying the role of social work in the correctional process, and to determining the best method of providing these social services to the courts.

Basically a social worker providing service to a court dealing with juvenile or adult offenders has two functions: First, to assist the judge in reaching a decision by providing him with pertinent information concerning the personality and social relationships of the person coming before him, and, secondly, to provide a skilled professional service for carrying out the corrective program approved by the court. If, for the time being, we pass over the question of authority, these functions require the exercise of the same techniques as those used by other social workers. Let us consider, then, some of the specific activities of such a social worker.

Helping offender to understand

The person brought before the court is interviewed by a social worker who is skilled in securing information that will be helpful in understanding and solving the personal and social difficulties that have brought the offender before the court. We who have been working in nonauthoritative agencies are keenly aware of the importance of this first contact with the people we hope to help. Picture, if you will, how very important it must be for the person whose personal problems have brought him into conflict with society as expressed in its laws. There are still too many places where the police authorities seem to be motivated by the belief that a good scare will have beneficial results. Actually, such treatment of an already disturbed person may establish an attitude which, at best, will cause withdrawal from all offers of help, but may also establish a deep-seated hostility to the court, its officers, and all the agencies connected with the administration of the law.

It is important, therefore, that the initial interview be conducted as soon after placement in detention as possible, in a setting conducive to mutual confidence, and by a person genuinely able by personality and training to be of help. In this initial interview the case worker begins the all-important work of establishing a relationship which the client will gradually be able to use in working through his difficulties.

At the same time information concerning the personality and social background of the client is obtained. The information obtained through direct interview is supplemented by material supplied by relatives and other informants, and by the results of medical, psychological, and psychiatric examinations. This is compiled and analyzed and brought to the judge for discussion.

At this point a new factor is injected into the picture—the judge, himself. Because of his central position in the court process, the attitudes of the judge have an immediate bearing on all the work done by the court. Unfortunately there is a tendency on the part of many judges to treat the social workers with whom they work as little more than glorified errand boys. This does not occur to the same extent in agencies providing help on a voluntary basis, since, although there may be differences of opinions, all persons involved—case worker, supervisor, and executive—are working within the same frame of reference. The judge, however, represents a different profession, with different methods and, sometimes, a different outlook. Unless he sincerely believes in the validity of the social-work method

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Given at the National Conference of Social Work, held April 13–19, 1947, at San Francisco.

and respects the professional competence and integrity of the social worker, little can be accomplished. I am not suggesting that the judge must surrender any of his rightful authority, but that he shall be sympathetic with the social worker's methods.

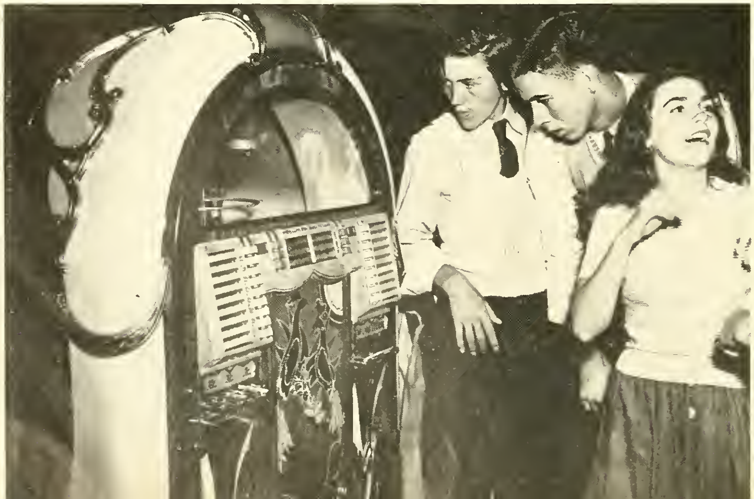
By the same token, the social worker must understand and appreciate the functions and responsibilities of the judge, as a specialized practitioner of a recognized profession. He must be willing to recognize that the forces that bear on the judge are different from those that may influence the social worker's decision, and that there is nothing inherently destructive in these pressures if the judge is a person of integrity.

We know that treatment of the offender begins at the first interview and continues throughout the period of contact, being refined and redirected as new diagnostic material is revealed. I am not advocating long periods of detention before disposition or trial, but I do urge that whatever time is spent in detention should be made as constructive as possible. The offender—whether child or adult—has undergone a markedly traumatic experience. He may be hostile and aggressive, or he may retreat into passivity. In either case we know that his experiences have created a psychological situation in which perhaps more than at any other time he will be able to respond positively to help. Now is the time when the social worker must begin skillfully to help him face the reality of his situation and to mobilize whatever strengths he may possess to deal constructively with his problem.

As quickly as possible the social worker develops a plan of treatment based upon the known facts concerning the offender and the available facilities. This plan is laid before the judge, who then has the responsibility for rendering judgment. Obviously the success of the whole program is dependent upon the adequacy and variety of treatment resources available to the court. A well-formulated plan for probation is meaningless unless the community provides an adequate number of well-qualified social workers. We are all aware of communities in which a pitiful handful of social workers are attempting to supervise a large number of persons on probation, who frequently are scattered over a wide geographical area. Under such circumstances the whole spirit and purpose of probation is lost, and a decision by the court to place an offender on probation is meaningless.

The same thing is true in the case of commitment to a correctional institution. I am sure that many of you have known situations in which all the factors in the case pointed to the desirability of a period of treatment in a controlled environment, but the correctional institutions were so inadequate that the court recognized that commitment could only have a harmful effect, and continued to try to work out plans outside the institution. Too frequently we tend to excuse our failures by blaming them on the recalcitrance of the individual rather than on the inadequacies of our own facilities. The real danger lies in the fact that our failure to provide the necessary facilities reflects upon the whole principle of modern probation and correction, with the result that communities, growing tired of failures, tend to return to the "good old days" when wrongdoers were securely locked behind bars and forgotten as long as the law allowed.

Information provided by a social worker concerning the personalities and social backgrounds of youthful offenders is helpful to the judge who must make a decision concerning them.



Social worker's responsibilities

Assuming, however, for the purposes of this discussion, that adequate facilities are available, the judge bases his decision upon the information presented to him and the points of law involved.

If the decision is to commit the offender to an institution, the social worker interprets to him the meaning of the decision and tries to prepare him for his institutional experience. Although certain individuals will find relief from their feeling of guilt in the fact that they are being punished, it is important that they be helped to approach the experience in such a way that they can utilize the program and facilities of the institution in attaining a more satisfactory personal and social adjustment.

The social worker should also assume responsibility for allaying any anxieties the offender may have concerning the welfare of his family. If the offender was the principal wage earner for his family, perhaps some other member of the family can be helped to secure employment through referral to employment or vocational-guidance agencies. In other cases, referral should be made to public-assistance agencies, and the social worker should be sure that the family receives all the financial help to which it is entitled. Members of the offender's family will frequently need help in working through their own feelings about the offender. In the case of a delinquent child, the child himself will need a great deal of reassurance that he is loved and that his misdeeds have not cut him off forever from the affection of his family. Finally, the social worker prepares a detailed summary of all the available information, which is forwarded to the institution for the use of the institution staff.

In those cases where probation is decided upon the role of the social worker is a continuing one. It is the function of the court to outline the terms of probation, but the social worker must interpret these terms to the offender in such a way that he understands them and recognizes their purpose. The fact that the probationer is not free to accept or reject his worker in no way alters the basic principle that case-work treatment can only be successful when the client is able to actively participate in the process. We should know that reliance on admonition and on the uncritical use of authority is useless. It is only when the probationer has been helped to recognize his need for help and to accept the social worker as the person able to give that help that real progress toward reintegration and reconstruction of behavior patterns can be made.

On the other hand, the worker who does possess authority in his relationship with his clients does not improve the situation by minimizing that authority or shying away from it.

Authority is integral to the probation setting, and only by recognizing the implications of that authority and using it with skill and understanding can the worker attain that sense of security in his own role and function which will make it possible for him to offer real help.

For example, adults, as well as children, will frequently be impelled to test their relationship with their worker. The probationer, although he knows the terms of his probation and has apparently accepted them, may violate his probation in various ways in order to see how far he can go.

If, on the one hand, the worker ignores these violations the probationer may feel that there is no real validity to the relationship and therefore it can be of no help to him. On the other hand, if the worker meets such a situation with hostility the probationer may come to feel that he has no alternative but to be submissive. Unfortunately any of us who are in a position where we must be submissive usually develop considerable hostility, and, when it is impossible to assert ourselves, this hostility may come out in many ways. The basic concept here is that in any situation the client needs to know the limitations within which he operates, and the person placing those limitations must be secure in his ability to do so, but the limitations should be acceptable to the client and not have the appearance of arbitrary exercise of authority.

Social workers recognize the recreational needs of young people who are on probation.

As the course of treatment proceeds the worker draws upon community resources to round out the case-work service which he is able to provide. This includes referral to public-assistance agencies if economic need exists, vocational counseling and employment agencies, medical and psychiatric facilities, and other services indicated which the community provides.

Judge kept informed of progress

Throughout the whole process the social worker has a responsibility to keep the judge informed of the progress of the individual probationer. It may be necessary to ask the judge to reconsider his decision if it is found that the probationer is unable to use the type of treatment provided. Finally, the judge must be advised when it would appear that the treatment has been successful and that the offender should be released from probation.

Having considered the role of the social worker in relation to the court, it is now important that we give our attention to determining how and under what auspices these services should be provided. In this phase of the discussion I will draw most heavily upon experience in the provision of services to juvenile offenders, because, as I indicated earlier, our practice and theory has developed more rapidly in this area than in the area of adult correction. However, the concepts which I wish to present can, I believe, be applied to the adult field. I believe that it constitutes the most basic question facing correctional workers today.

When the juvenile-court movement started, around the turn of the century, most of what passed for skilled case work was being provided by private agencies, usually under sectarian auspices. Even in large cities there were only a few persons aware of the new thinking about the causes of antisocial behavior and of the ways of treating persons exhibiting such behavior. It was logical, therefore, that persons interested in court reform and the socializing of court procedures should direct their efforts toward the courts themselves. As a result judges, either willingly or unwillingly, were required to employ social workers as juvenile probation officers and, in order to remove children from the common jails, were given responsibility for the establishment and administration of fairly elaborate detention facilities. All this meant considerable change in the traditional concept of the court's function as an arbiter and interpreter of questions of law and legal status.

The tremendous growth in our knowledge of human behavior was accompanied by a parallel development in the concept of public responsibility for the welfare of people.

Federal-State cooperation

In 1935, with the passage of the Social Security Act, the financial resources of the Federal Government were made available to help in providing not only economic security, but also social services, particularly to children, in all parts of the country. As a result, although we are far short of achieving our goal, we can now talk realistically of plans to provide skilled child-welfare workers in every county of every State.

Unfortunately, and I say this with full awareness of the magnificent work done in many places by outstanding courts under the leadership of conscientious and enlightened judges, the juvenile courts generally have not kept pace with the progress made by the child-caring agencies.

In too many instances considerations of political expediency or of shortsighted economy have overweighed sound social planning. Standards for the selection of personnel have not been as high as those established by the public children's agencies.

In many places there is wasteful duplication and overlapping of services which is confusing to the public and prevents efficient rendering of services to the children who need them.

Especially in the area of protective services for children, the courts are heavily burdened with a large number of cases which do not actually need judicial consideration. For example, situations involving neglect present problems which in nearly all instances can be dealt with by a competent case worker without the necessity of court action. In those instances where the situation requires the exercise of authority it is possible for the case worker to secure the necessary court orders removing the child from the parent's custody. In my own State, such a child may be, and frequently is, committed to the custody of the county welfare department.

Furthermore, it is not necessary to assume that the child who has committed an offense against society must therefore be treated by the judicial agency. Most delinquent children or their families have been known at one time or another to some social agency, and more frequently than not the agency has had a close and continuing contact with the child and his family over a considerable period of time. To break this relationship and transfer the child to a completely different agency simply because he has been adjudicated delinquent is harmful to the child and wasteful of the community's resources.

Interestingly enough, this concept of a unified and continuing service to all children has developed by force of circumstance in many of our smaller communities. In such communities the State department of welfare, by using the available Federal funds, has been able to provide a skilled child-welfare worker when the community could not or would not provide from its own resources for a juvenile probation officer. The child-welfare workers have been able to demonstrate to the judges that they had a service to offer to the court which could be provided successfully outside the actual structure of the court.

In the larger centers, where the court structure is more complex and there has already been an investment in personnel, buildings, and equipment, the idea has been slower in taking hold.

However, even in the large urban centers, the public-welfare departments and voluntary agencies are providing an increasing amount of service to the courts, and are providing care, at the request of the court, to many children with serious behavior problems.

I am presenting, therefore, the following suggestions:

1. Care of socially and psychologically handicapped children is basically a public responsibility that can best be fulfilled by a State agency. The services of such an agency can draw upon local, State, and Federal resources, and can be supplemented by specialized services under private auspices. These services should be developed as rapidly as possible to the point where any child exhibiting difficulties in adjustment to society may receive skilled care, and should be sufficiently varied in scope to provide service in the child's own home, in foster homes, or in institutions, depending upon the child's individual requirements.

2. The courts should return to their primary responsibility of determining questions of law and legal status, but in the exercise of this function the judge should utilize the services of the social agencies in arriving at a sound decision.

3. The public and private child-caring agencies must recognize their responsibility to provide the best possible service to the court and to the children brought before the court.

4. Both courts and social agencies must clarify their thinking with respect to the types of situations which require judicial determination.

Space does not permit a discussion of whether these unified services should be provided by a child-welfare division of a public-welfare agency, or by a State children's department, or of the tremendously important role of the voluntary agencies. However, I am convinced that only as we succeed in unifying all public services to children under one agency will we achieve the goal toward which we are striving.

Reprints available in about 5 weeks

A judge may decide that institutional care is needed by a youngster. Such care will offer better opportunity for personal and social adjustment if the decision is based on study by a social worker and if the boy or girl has been well prepared for the institutional experience.

MAKE WAY FOR YOUTH

JUANITA LUCK,

Specialist in Planning for Children and Youth, Office of the Chief, U. S. Children's Bureau

Make Way for Youth is a motion picture that should inspire parents, teenagers, civic leaders, and other people to help make their home town a happier and better place to live in.

The picture recognizes that if a community fails to encourage its young people to take part in civic life, then that community is creating a "youth problem" for itself. It illustrates further how youth can make a valuable contribution to the common good when they are supported by the adults of the community in their efforts to achieve their rightful status.

The Youth Division of the National Social Welfare Assembly presents this 20-minute picture as a supplement to a booklet that this organization has recently issued, Youth United for a Better Home Town.

Both the movie and the booklet call upon local youth leaders to do three things:

1. To help young Americans develop skills of citizenship;
2. To give youth the opportunity of making their voices and their energies felt in the future of neighborhoods, their towns, their world;
3. To work with young people in building a program of learning to live together—a program that can equip youth for the adult job of building peace.

That sounds like a big order, says the Youth Division, in Youth United for a Better Home Town. And it is.

And that is why the 21 national youth-serving organizations that make up the Youth Division of the National Social Welfare Assembly are urging the cooperation of their local professional and volunteer workers. They are urging that these workers take part in helping the young people of their community to form a youth council—a community-wide, teen-age interorganization council of "Youth United" for a better home town.

In the movie the boys and girls who play the roles of the teen agers that get together to form a youth council are members of the Youth Council of Madison, Wis., the city where the screening was done.

The picture was first shown November 19, 1947. Simultaneous premieres were held at New York City and at Madison.

Make Way for Youth shows how teen agers of a town in the Midwest got together to form a youth council, with older people as advisers only. It shows how the council helped to break down the "fences" that had been separating the young people of different neighborhoods, races, and religions, as well as their elders.

Delegates to the new youth council came from every youth organization in town. The Y. M. C. A. and the Y. W. C. A. were represented; also the Boy Scouts, the Girl Scouts, and the Camp Fire Girls. Then there were the Junior Red Cross and the 4–H Club; the Future Home Makers and the New Homemakers. The high schools, the church clubs, and the settlements sent delegates.

The young people came from all kinds of neighborhoods—the well-to-do part of town, and the not so well-to-do parts, and from a section some people called the Swamp.

How the youngsters managed their youth council, and how their success in working together regardless of race, religion, or any other dividing lines, helped to unite the town, is the story that the film tells.

The Youth Division of the National Social Welfare Assembly is made up of the following member organizations: American Jewish Committee; American Junior Red Cross; American Youth Hostels; Boys' Clubs of America; Boy Scouts of America; Camp Fire Girls; Community Chests & Councils, Inc.; 4–H Clubs; Future Farmers of America; Future Homemakers of America; Girl Scouts; National Council, Y. M. C. A.; National Board, Y. W. C. A.; National Federation of Settlements; National Jewish Welfare Board; New Farmers of America; New Homemakers of America; Salvation Army; United Christian Youth Movement; United States Children's Bureau, Federal Security Agency; and Youth Department, National Catholic Welfare Conference.

For further information concerning the film, Make Way for Youth, and the booklet, Youth United for a Better Home Town, write to the Youth Division, National Social Welfare Assembly, 134 East Fifty-sixth Street, New York 22, N. Y.

Members of a youth-council committee meet to work out their problems with adult advisers.

IN THE NEWS

To Study Causes of Congenital Defects

In an effort to collect more precise data on the relationships between certain maternal infections and congenital malformations, a Nation-wide study is being sponsored by the American Academy of Pediatrics and the National Society for the Prevention of Blindness. Questionnaires are being sent to obstetricians, ophthalmologists, and pediatricians, seeking the reporting of cases of German measles in expectant mothers and of children with congenital defects that might be attributed to other infections in the expectant mother, such as measles, chickenpox, mumps, and influenza.

Although an association has been established between the occurrence of German measles early in pregnancy and certain congenital defects in the offspring, information is lacking as to the frequency with which this happens and as to the possible influence of other communicable diseases that might have been contracted by the expectant mother.

American Legion Holds Child-Welfare Conferences

The first of five area conferences on child welfare, which are held each year by the American Legion's National Child-Welfare Division, met December 4 to 6 at Phoenix, Ariz. The area covered by the conference (area E) includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

At the Phoenix meeting one full session was devoted to discussion of what constitutes a comprehensive child-welfare program in a State and in a community. Emphasis was placed on the importance to child welfare of three of the programs in which the Federal Government cooperates with the States under the Social Security Act—Child-Welfare Services, Aid to Dependent Children, and Old Age and Survivors Insurance—and on the relation of these to State and local child-welfare programs.

The other four area conferences scheduled are:

Area D, January 9 to 10, 1948, at Columbus, Ohio (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin).

Area A, February 6 to 7, 1948, at Providence, R. I. (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont).

Area B, February 13 to 14, 1948, at Washington, D. C. (Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia).

Area C, March 5 to 6, 1948, at Memphis, Tenn. (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas).

International Statistical Conference Held

More than 35 nations were represented at the International Statistical Conference, held in Washington, D. C., September 6–18, 1947.

Among the contributions of interest to workers in the children's field was a paper by Louis I. Dublin, which demonstrated a significant reduction of mortality among the policy holders of a life-insurance company between 1911 and 1946, and indicated that the most striking reductions occurred among children. For example, the decrease in mortality among children 1 to 4 years was 87 percent. This means, said Dr. Dublin, that for every child who now dies at those ages more than seven would have died if the mortality conditions at the beginning of the period under review had prevailed at the end of it.

One of the first censuses taken on modern lines—in Iceland in 1703—was described by Thorsteinn Thorsteinsson, director of the Statistical Bureau of that country. The original census material had been rediscovered in good condition in the Danish National Archives in 1921, and returned to the Government of Iceland. This very early census includes age composition of the population by sex and marital status, and information on family status (heads of families, wives, children and foster children, servants, and so forth).

In a paper on the fertility of women in the United States, P. K. Whelpton, associate director, Scripps Foundation for Research in Population Problems, concluded that although fertility is still declining rapidly in the United States, we may expect that this decline will be retarded, possibly within the next few years, and certainly within the next quarter of a century.

International organizations that were represented included the United Nations (World Statistical Congress); the International Statistical Institute; the Inter-American Statistical Institute; the Econometric Society; the International Income Conference (International Association for Research in Income and Wealth); and the International Union for the Scientific Investigation of Population Problems.

George Wolff, M. D.

For Research in Human Reproduction

A comprehensive program for research in the field of human reproduction has been announced by the National Committee on Maternal Health. The research program will be under the direction of the National Research Council in Washington. The Council has already established a committee on human reproduction to study needs and then to recommend grants for specific research projects to qualified institutions and individuals.

Do You Know the Mental-Health Laws of Your State?

Two volumes of Mental Health Laws in Brief, one for Kansas and one for Pennsylvania, have been recently issued in mimeographed form by the National Committee for Mental Hygiene and the National Mental Health Foundation. These two books are part of a series which is planned to cover all the States of the Union. ($1.50 each. National Mental Health Foundation, 1520 Race Street, Philadelphia 2, Pa.)

These brief statements have been prepared to enable ordinary people to know what the customs of their State regarding the mentally ill are as expressed in their laws. The work is dedicated to "the first human being who is cured and released from institutional restraint because of improved conditions, care, and treatment, through an awakened and informed citizenry's insistence that means for such improvements be found."

Dr. George S. Stevenson, medical director of the National Committee for Mental Hygiene, in a foreword, reminds readers that even if laws are on the statute books they become ineffective unless the budget provides for carrying them out.

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"The United Nations Appeal for Children offers individual men and women throughout the world a unique opportunity to take a direct part in the work of the United Nations. It is based on the most irresistible of all causes: the plight of hungry, homeless, hopeless children, innocent victims of war and famine."

Trygve Lie

• FOR YOUR BOOKSHELF

PARENTS' QUESTIONS; a handbook by the staff of the Child Study Association of America. Harper & Bros., New York. Revised 1947. 256 pp. $3.

Having "Parents' Questions" in the house is like having a wise friend at hand to whom one can turn with almost any problem that comes up, from a 4-year-old boy's fear of an operation to a 10-year-old girl's tomboy behavior.

The broad background and long years of practical experience of the Child Study Association enable its staff to see all around a question. These brief but penetrating answers do not approach just one angle of the matter about which the parents are concerned; they bring to light many things about the situation that may have escaped the questioner, absorbed in some one distressing or annoying aspect.

Nor do these sympathetically worded paragraphs attempt to give "all the answers." Often their purpose is to arouse parents to deeper and closer thinking, as in the case of the 11-year-old who "never wants to play outdoors after school like other children." The "answer" to this question is mostly in the form of other questions, without which there would be little chance of helping the parents find the real nature of the problem.

A social worker, nurse, teacher, or any other person who works with parents or children will want to turn to this book again and again. Its lucidity, its wide range of subject matter, and its reassuring friendliness have made it, since its first appearance in 1936, one of the best helps available on those puzzling situations that are common to family life and yet are unique in each case because of the complex interplay of personal relations. The new edition, which has "tried to make use of the increasing knowledge and the deepening insight" that have come in the last 10 years, will be eagerly turned to by old friends, as well as new ones.

Marion L. Faegre

EXPECTANT MOTHERHOOD, by Nicholson J. Eastman, M. D. Second edition, revised. Little, Brown & Co., Boston, 1947. 198 pp. $1.50.

Dr. Eastman, author of this book for mothers-to-be, is Professor of Obstetrics at Johns Hopkins University and Obstetrician-in-Chief to the Johns Hopkins Hospital.

In his preface the author states that he hopes the book may serve "as a sort of stenographic recapitulation of the doctor's main instructions, which may be reviewed leisurely at home." He recognizes, however, that there are many details the expectant mother wishes to know which her busy obstetrician has no time to tell her. The discussion of these he considers an important function of his book. The happy combination of accurate, authoritative information with a simple readable style makes it a book which should appeal to a wide group of readers.

The content of the book is chronologically complete, beginning with signs and symptoms of pregnancy and ending with the newborn baby. High points along the way are the comprehensive chapters on diet and weight control, in which Mrs. Eloise R. Trescher of the Johns Hopkins Food Clinic has contributed her valuable experience. The eight steps in eliminating extra sources of calories is a practical measure which few physicians remember in diet counseling. An ingenious inclusion is a section, "How to telephone your doctor," which stresses accurate observation and reporting in order to save the time of both the doctor and patient. This section, indeed, is applicable to any doctor-patient relationship, and need not be limited to obstetrics.

In a brief chapter on the Rh factor, Dr. Eastman brings together all the most recent experimental evidence and reaches the "comforting conclusion" that the "mathematical chances of the expectant mother who is reading these lines losing a baby from Rh complications . . . is of the order of 1 in 600."

Dr. Eastman's discussion throughout is based upon the assumption that the patient will have adequate prenatal care and good obstetrics.

Everywhere among the practical everyday points there is ample evidence of the sparkle of humor, the kindly understanding, and the real professional competence that characterize the author.

Ann Peters, M. D.

MEDICAL SOCIAL WORK (Occupational Abstract No. 98—1946), and SOCIAL WORK (Occupational Abstract No. 88—1945). Both by Florence L. Rome. Published by Occupational Index, Inc., New York University, Washington Square, New York 3.

These are two of a series of folders issued to help young people choose their life work. They describe concisely the nature of the jobs in medical-social work and in the other major fields of social work, tell what preparation is needed, and discuss earnings, prospects, and so forth. They refer the reader to other sources for additional information.

New Zealand

(Continued from page 87)

The total number of treatments given in the year covered by the annual report was 1,572,156. This included 871,450 reparative fillings, in both permanent and deciduous teeth, and 194,667 preventive fillings, a total of 1,066,117. The number of teeth removed as unsavable (or in some cases to relieve overcrowding) was 68,656, a ratio of about 6 extractions to every 100 fillings.

As of March 31, 1946, the school dental service was given at 447 centers; the professional staff numbered 641, including 390 school dental nurses and 183 student dental nurses.

• CALENDAR

Dec. 27—Society for Research in Child Development, National Research Council. Meeting in connection with the 114th meeting of the American Association for the Advancement of Science, Chicago, Ill.

Dec. 28–30—American Statistical Association. Joint meeting with American Sociological Society, Institute of Mathematical Statistics, and American Association of University Teachers of Insurance. New York, N. Y.

Jan. 5–10, 1948—Ninth Pan American Child Congress. Caracas, Venezuela.

Jan. 22–24, 1948—American Association of Schools of Social Work. Minneapolis, Minn.

Jan. 28–30, 1948—National Commission on Children and Youth. Washington, D. C.

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School children in a happy group appear on our cover this month. Emphasizing the *individual* child, Alma S. Laabs, in this issue of *The Child*, describes the work of school social workers in solving children's personal difficulties. Photograph, St. Louis Public Schools.

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Strengthen Research Into Child Life

Sixteen distinguished research workers, meeting with Children's Bureau staff on November 4 and 5, came to some important conclusions about next steps in research in child life.

In the group were specialists in child psychology, pediatrics, social work, child psychiatry, cultural anthropology, sociology, and social philosophy.

All of them had been invited together by the Children's Bureau to explore the need for research in child life, the directions it should take, and the role of the Children's Bureau in this field.

Vital questions were threshed out by the group.

How, for instance, can research in child growth and development move out of the clinic into the community? Much of the research in the past, it was pointed out, has been with children in institutions, centers, clinics, and offices. Isn't it time that more researchers worked with children in their normal family and neighborhood environment?

"The family as an institution is undergoing rapid changes." What lessons are there in this for the social services, for education, for public policy? Data are needed on the "genesis, character, and direction of child-bearing patterns." These, it was said, must be studied as a cultural anthropologist would study them. Are health and welfare workers doing a disservice "in attempting to disarrange" some of the customs of child rearing found in different cultural groups in the country? What are the personality and environmental factors behind various kinds of child behavior—such as juvenile delinquency? What are other countries doing to give babies a good start in life by providing benefits and services to expectant mothers?

Questions such as these are not to be answered in a day. They call for continuous pooling of thought and experience. That is why the conference unanimously recommended that the Children's Bureau appoint an advisory committee on its research program, representing all the professions touching on the problems of child growth and development. Such an advisory committee, it was said, should work on over-all long-term policies. It should define research projects that can best be done by a Federal agency and those best done by a more decentralized project. It should stimulate volunteer cooperative planning, define standards, and advise on methodology.

"A research program involving the development of child life is too big for any single discipline to grasp," said the conferees. "It must be an integrated effort." "Health, growth, and development mean much more now than when pediatrics became a specialty. Its study must include more than a purely medical approach; it must embrace the sociological, economic, and social-worker approaches."

That kind of interdisciplinary research is characteristic of many of the Children's Bureau research projects in the past. It should be encouraged in the future. As one device for encouraging such research, the Bureau was urged by the conferees to provide a "clearing house" of information on ongoing research. A yearly or semiyearly bulletin should be published "so that all of us can know where all the research is going on in the country and who these research people are." It was also recommended that the Bureau publish some kind of "basic data book" which would collate essential information relating to child life and to administrative programs affecting children.

To strengthen research outside of government, the conference recommended to the Children's Bureau "the early establishment of grants in aid for research in the field of child life for the purpose of supporting such research in non-Federal agencies."

The Bureau is deeply grateful to the group who gave their time to advising the Children's Bureau on next steps in developing a more inclusive, better knit, and more extensive national program of research in this vital field. We see in the extension and strengthening of research in child life an activity that can be a creative and binding force among all peoples in the land.

Martha M. Eliot

MARTHA M. ELIOT, M. D.,
Associate Chief,
U. S. Children's Bureau.

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Katharine F. Lenroot, Chief

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ANUARY • 1948

the CHILD

TOWARD BETTER CARE FOR RURAL MOTHERS

MAR 3 1948

JOHN WHITRIDGE, JR., M. D.,
Obstetrical Consultant,
Maryland State Department of Health, Baltimore

THIS IS the story of what one State, Maryland, has been trying to do to improve rural obstetrics. It is presented with the full realization that it is only a small beginning and not a finished product. If, however, anyone finds in this any worthwhile ideas or can give me suggestions and criticisms which will bring about an improved rural maternity program, then the story is worth presenting.

For the purpose of organizing a fairly close-knit maternity program, Maryland is fortunate by virtue of its small size. The State, insofar as health activities are concerned, is divided into two distinct administrative units, namely, the city of Baltimore, under the city health department, and the remaining 23 counties of the State, under the Maryland State Department of Health. Each of these divisions contains approximately half the total population of the State, that is, about one million people each. The story that follows concerns the million who live in the rural areas of Maryland, outside the city of Baltimore, and who are served by the Maryland State Department of Health.

The State health department entered the field of maternity care in Maryland in 1928, establishing at that time a single clinic in one of the counties not far from Baltimore. This clinic was conducted by one of the local physicians, paid on a session basis. Since then the prenatal program has expanded gradually and steadily until at present there are 53 clinics operating throughout the State. During 1946 these 53 clinics held 976 sessions and furnished prenatal care to over 2,600 women. It is important to point out that this expansion has been carried out with the active cooperation and consent of the individual local physicians and the local county medical societies. In no instance has any attempt been made to set up clinics in areas where there was any concentrated opposition to the ideas; and in every instance local physicians have been urged to conduct the clinics for the health department. Again, conditions in Maryland are fortunate in that there has been built up over the years a carefully nurtured good will between practicing physicians and the health department. Without this good will, the program would be impossible.

Six types of workers are involved in the operation of our maternity program: (1) The local practicing physician, (2) the general-staff public-health nurse, (3) the deputy State health officer, or county health officer, (4) the certified nurse-midwives, (5) a public-health-nursing consultant in obstetrics, (6) a physician, who is an obstetric consultant.

Local practitioners in most of the counties have cooperated by agreeing to conduct the prenatal clinics. In this way the local man is made to feel that he is part of the program and not merely looking in from the outside. For such services he is paid $8 for a half-day session and $15 for a full-day session. In 1946, 33 physicians were carried on the health-department pay roll for such services.

It must be admitted that in many instances physicians are simply too busy or are not interested in contributing their time for such small remuneration, but constant efforts are being made to interest new men in taking part in the program. Our hope is eventually to have two or more in each community who will give their time to this project.

The general-staff public-health nurse gives approximately one-quarter of her time to prenatal and maternity work. She usually is the first person outside the family circle to learn that a patient is pregnant. She often knows the patient's individual problems, and she takes an active part in seeing that the patient either reports to the physician of her choice or attends one of the prenatal clinics. From this point on, the general-staff nurse sees the patient, both through home visits and at the clinic, throughout her pregnancy, instructs her concerning her care, and helps her with her plans for delivery and for care of the infant.

The deputy State health officer has the same function here as elsewhere in the country. He serves as administrative head of the local health-department unit. As such he authorizes and schedules the prenatal clinics, furnishes nursing personnel to conduct them, and arranges, wherever possible, with the local physicians to conduct the clinics. The success or failure of the maternity program in any given county is dependent largely on the interest, initiative, and tact of the individual health officer and his relationship with the local physicians and the local county medical society. In those instances in which local physicians do not conduct the prenatal clinics, the deputy State health officer takes over this function himself and examines and instructs the patients.

When physicians are scarce

The certified nurse-midwives are, of course, graduate nurses who have had specialized postgraduate training in maternity work. They have been assigned to those areas in the State where physicians are most scarce and hospital facilities meager or lacking. At present in Maryland only six are employed, but four or five times that many could be used if they were available.

These nurse-midwives devote their entire time to the maternity program, arranging, attending, and helping with the prenatal clinics, making home visits to prenatal and postpartum patients, carrying out deliveries in the home, and keeping a close eye on the activities of the local "granny midwives." The work of the granny midwives is unfortunately still necessary in many of the more remote areas of the State. In 1945 these untrained midwives performed 7 percent of the total deliveries in the counties.

The nurse-midwife can book for delivery only those women who have been examined and found normal by a physician. When in difficulty, she calls either

Paper given at Third American Congress on Obstetrics and Gynecology, September 8–12, 1947, St. Louis.

Regular medical supervision helps to make her pregnancy safe.

A certified nurse-midwife weighs a baby while the family look on.

the deputy State health officer or one of the local practitioners for advice.

The public-health-nursing consultant in maternity care is likewise a certified nurse-midwife, who operates out of the central health-department office and goes from county to county helping the general staff nurses with their maternity work, advising the nurse-midwives, and instructing and inspecting the granny midwives. She helps in the establishment of clinic routines, home-visit techniques, and all aspects of prenatal, delivery, and postpartum care that relate to nurses, nurse-midwives, and granny midwives. In this capacity she visits, from time to time, all the 23 counties of the State.

The last member of the maternity team is a physician, the obstetric consultant. This position was first created 10 years ago on a part-time basis, but as the work developed, it became apparent that it demanded the full-time services of at least one person. At the present time, there is a single obstetric consultant who is able to devote his entire time to this work without having to take time for private patients of his own. The great disadvantage of employing a man in this capacity on a part-time basis had proved to be the fact that so often he found it necessary to cancel clinic visits at the last minute because of his private practice.

The consultant travels from county to county on a prearranged schedule and visits certain of the prenatal clinics while they are in operation. All clinic patients having abnormalities or suspected of having them are referred to the clinics he attends. His major function in respect to the clinics is, therefore, the examination of abnormal cases and the making of necessary arrangements for their proper care. In this way he comes into contact with the deputy State health officers, the local physicians, the staff public-health nurses, the nurse-midwives, and on occasion, the granny midwives.

Matters of maternity care in general, and those relating to specific patients, are discussed at these clinics. In addition, the consultant renders, when requested, free consultant service to any of the physicians of the State. He remains on 24-hour call for this purpose and sees patients in either the physician's office, the patient's home, or the hospital.

When time and travel permit, he will go to help out with difficult deliveries. He appears before local medical-society groups to give talks on obstetric subjects and holds informal discussion groups. Recently there has been a gratifying move on the part of the rural hospitals to ask his advice in improving their maternity sections, and in one instance, he has been placed on the consultant staff of a local hospital.

Lest you think he must be like a cat with nine lives to be able to accomplish all this, it must be admitted that the demands upon him are not equal to his willingness to help. Free consultation service is a new idea, and like everything else that is free is looked upon with some skepticism of its value. The progress along this line is slow, but is still progress.

An extremely important feature of the obstetric consultant's status is a close working arrangement with a teaching hospital. In addition to his position with the health department, he is likewise on the staff of a teaching hospital in Baltimore. This makes it possible for him to arrange hospitalization in a teaching hospital with a large obstetric service for any patient, regardless of her financial status, who presents any major obstetric abnormality needing specialized care. He can obtain any special form of study or treatment which cannot be gotten locally. His association with a teaching hospital further serves to keep him abreast of current advances in obstetrics. And lastly, it facilitates arrangement of postgraduate courses in obstetrics for rural practitioners. This was done for the first time this year, when a total of 31 physicians attended a 10-day postgraduate course at the two teaching hospitals in Baltimore.

From the patient's point of view, here is a plan that assures that any expectant mother in Maryland, irrespective of her financial status, can obtain modern obstetric care and advice.

Clinic examination includes all the usually accepted basic examinations: Pelvic measurements; blood studies, in-

(Continued on page 109)

CHILDREN'S BUREAU REVIEWS A YEAR'S WORK

This is a condensed and somewhat rearranged version of the thirty-fifth annual report of the Children's Bureau, for the period July 1, 1946, to June 30, 1947. The complete report can be found in the Annual Report of the Federal Security Agency, as part of section 1, which is the report of the Social Security Administration.

BASIC to all the work of the Children's Bureau is its responsibility, under the act of Congress creating the Bureau in 1912, for investigating and reporting "upon all matters pertaining to the welfare of children and child life among all classes of our people."

Little occurs in the economic, social, and cultural life of the Nation that does not in one way or another impinge on the welfare of children and child life. Since the Bureau must work within the limits of its personnel and budget, it must be selective in its investigations and reporting, focusing its efforts on areas where there is most need for information and where information can best be used in helping public and private services increase their usefulness to children.

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Research

The year 1945 was a banner year for the United States in the safeguarding of mothers and children from fatal risks in childbearing and in infancy. The maternal mortality rate, 20.7 deaths for each 10,000 live births, was the lowest ever recorded in this country and 9 percent below the 22.8 recorded for 1944. The infant mortality rate as conventionally computed declined from 39.8 for each 1,000 live births in 1944 to 38.3 in 1945. When adjusted for the changing number of births, the rates were 39.4 in 1944 and 38.2 in 1945, a decline of 3 percent. Preliminary figures for 1946 indicate a further decline.

Despite the encouraging showing in national rates, maternal mortality in some States, particularly among nonwhite mothers, was disproportionately high. Analysis of mortality rates in 1944 indicates that reduction in maternal mortality among nonwhite mothers lags 15 years behind that for the rest of the population.

A study of neonatal deaths emphasized again the importance of concentrating attention on risks in the first month of life if the infant mortality rate is to be lowered significantly in coming years. While death rates for the first year of life dropped 29 percent from 1935 to 1944, rates for the first month declined only 24 percent. Sixty-two percent of all infant deaths in 1944 occurred when the infants were less than a month old. Prematurity is the greatest single cause of infant mortality; at least two-thirds of these deaths from prematurity could be prevented if the infants could receive care in modern "premature centers" with specially trained medical and nursing personnel.

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By June 30, 1947, all States were participating in the study of child-health services undertaken by the American Academy of Pediatrics with the cooperation of the Public Health Service and the Children's Bureau. The Bureau has aided this study, the most comprehensive one of its kind ever undertaken in this country, by lending the director of its Division of Research in Child Development and a research assistant to the executive staff of the study. . . .

Studies to develop plans for dental-health services for children continued during the year. One was an evaluation of a dental-health program for elementary-school children, involving the analysis of dental records collected through the Cleveland Department of Education Dental Health Service. Records of mobile dental units serving children in rural areas in Kentucky were studied to obtain data on cost, coverage, man-hours, types of services, and the time necessary for various operations. A study of the budgets and expenditures for dental-health programs of all State health departments from

1937 through 1946 was started. In June 1947 the Bureau held a conference with authorities on orthodontic needs of children and the methods, services, and problems involved in meeting those needs.

In cooperation with the National League of Nursing Education, the Bureau made a controlled study of the elements that go to make up good pediatric nursing care in hospitals. Results of the study have been published by the National League and so made available to hospitals and others responsible for standards of nursing care of sick children.

A conference was held of representatives from the fields of education, medicine, nursing, medical social work, and welfare, to advise on a study of the various vision-testing procedures commonly used in elementary schools. The study is to be made jointly by the Bureau and the National Society for the Prevention of Blindness, with the cooperation of a State health agency.

The increasing number of children entitled to benefits under various public programs makes timely a study of laws and procedures governing the legal guardianship of children. Many such laws are antiquated, and practices under them have lagged far behind modern knowledge of the social needs of children. The Bureau will soon issue the final report on its study of court records, procedures, and cases of children under guardianship in two local jurisdictions in each of six States.

Advisory services on problems affecting children

Consultation service was given to States and local groups in the field of juvenile delinquency and community planning for children and youth. In addition, the Bureau completed several special studies in that field. The report of the Bureau's 7-year project in St. Paul, Minn., demonstrating the value of integrated community services for children showing early behavior problems, was published under the title, "Children in the Community." . . .

The method of reporting juvenile-court statistics, collected by the Bureau each year since 1927, was revised to attain broader coverage through collection of local data by State agencies, and to yield information both on the types of cases disposed of and on the number of children involved. Final figures for 1945 show a 6-percent increase over 1944 in the number of delinquency cases disposed of by courts reporting to the Children's Bureau in both years.

Much staff time went into preparing material for consideration by the National Conference on Prevention and Control of Juvenile Delinquency, called by the Attorney General.

There have been reports of inadequate, if not positively bad, care and treatment of boys and girls in training schools in many States, because of poorly qualified personnel and inadequate facilities. Several State schools were visited, and suggestions were given on improving standards of service and integrating State training-school programs into State child-welfare programs. At the request of the Child Welfare Division of the American Legion, a study was made of the policies and practices of 22 States in admitting pregnant feeble-minded and epileptic girls to State training schools.

In connection with the wide variety of requests that come to the Bureau for information and counsel on problems connected with the care of children away from their homes, considerable exploratory work was done during the year in collating facts about current and desirable practices on such aspects of foster care as foster-home finding, intake policies, size of case loads, board rates, costs of institutional care, personnel practices, in-service training programs, foster-parent education, licensing, and general standards of care. Special attention was given to problems of interstate placement.

Agencies seek help

It becomes increasingly evident that the public is looking to public welfare agencies for guidance and assistance in adoption matters. These agencies, in turn, look to the Children's Bureau for counsel in the development of their policies. Advice on adoption policies was given also to private agencies. The Bureau's consultant on adoptions worked with the March of Time on its

What the Social Security Administration recommends on Children's Bureau programs

Legislation and appropriations providing for the progressive development of State-wide programs at a rate consistent with availability of personnel and with facilities that meet standards established under State plans, for the purpose of assuring that child health and welfare services will be available as needed for all children in all political subdivisions of each State. Provision of such services without discrimination as to race, creed, nationality, residence, citizenship, or economic status.

Development within the health and welfare programs of measures necessary to assure that children in migrant families will receive the services they need.

Priority of attention to development of programs of health, medical, and dental services for children of school age.

Safeguarding the rights of parents and children to such services by requiring that State plans provide an opportunity for fair hearing before the State agency responsible for the program, whenever a claim for care or services under the plan is denied; and adequate restrictions on the use or disclosure of information concerning persons applying for or receiving such services to purposes directly connected with the administration of such services.

Special provision of financial aid in training of professional and technical personnel needed in making child health and welfare services available throughout the country.

Effective coordination of the health and welfare services for children with other health and welfare services.

Administration of the maternal and child health and crippled children's services by the same State health agency in each State by the end of a 5-year period.

Appointment by each State agency administering maternal and child health and crippled children's services of a general advisory council providing adequate representation of the public as well as of the professions.

More adequate financial implementation of the basic act of 1912 creating the U. S. Children's Bureau, to enable that Bureau to strengthen and broaden its work as a center of information related to children; to evaluate current research in the physical, biological, and social sciences that pertain to the growth and development, the health and well-being of children and young people; to assist in financing specific research projects by competent research authorities to fill in recognized gaps in these fields of research; and to undertake research and investigations that deal with the child as a whole or with specific problems that require Nation-wide study or that have Nation-wide significance to State and community health and welfare programs for children or mothers.

special feature, "Nobody's Children." The Bureau's folder on adoption was reissued under the title, "When You Adopt a Child."

There is a continuing need for day-care services for children, but the supply is diminishing. Requests for counsel received from Federal, State, and local agencies by the Bureau covered problems of licensing, standards, building requirements and equipment, and methods of appraising need for programs. An interpretation of foster-family day care was published under the title, "Mothers for a Day."

Interest in improving services to unmarried mothers and their babies has become Nation-wide. The Bureau was called into consultation by public and private agencies in several States. Improvements were reported during the year in methods of birth registration as one means of safeguarding the welfare of children, particularly those born out of wedlock.

The Bureau's advice on homemaker service has been sought by both private and public welfare agencies, which are making more use of homemaker services to give trained and supervised care for children in their own homes.

Increasingly, agencies are recognizing the therapeutic value of group work, as distinct from individual casework, with children. The Bureau advised several States on the use of group work in convalescent-care programs and camping programs for children with physical handicaps.

For migratory workers' children

Evidence of the health and welfare needs of children of migratory workers, among the most neglected in the Nation, was presented by the Bureau at meetings of the Federal Interagency Committee on Migrant Labor, of which the Children's Bureau is a member. In recommending that all appropriate State and Federal agencies carry through practical measures "which will insure adequate housing, health, nutrition, welfare, and related services," the committee made suggestions on how conditions for children might be improved.

Advice on services for children in minority groups was given by the Bureau to several national organizations, public welfare agencies, and private child-caring agencies.

"When You Adopt a Child" is the title of a Children's Bureau folder that endeavors to answer some of the questions raised by persons who are thinking of adopting a child.

Great increases in college enrollments of married students with families have created problems for public health and welfare agencies. At the request of the American Council on Education, the Bureau cooperated in a survey of community services needed for the care of these families.

To meet the growing volume of requests for guidance in the use of psychological and psychiatric services by public health and welfare agencies in all programs of foster-family and institutional care of children, the Bureau conducted a number of field investigations during the year. Visits were made to public and private agencies in several States to observe services for children with disturbed behavior.

On behalf of the Interagency Committee on Youth Employment and Education, the Chief of the Children's Bureau, who was chairman of the committee, late in 1946 submitted a report and recommendations to the Director of War Mobilization and Reconversion. The report summarizes the observations of 11 Federal agencies on problems of school and employment opportunities for young people and lack of community preparation to deal with youth's needs in the postwar period.

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Reporting services

Information about the research findings mentioned here and about other studies now under way is available on request from the Bureau. Results of the Bureau's studies and surveys are communicated to public and private agencies administering programs for children. In its monthly periodical, *The Child*, and through other mediums, the Bureau discharges its responsibility of reporting to the public and to professional workers on all aspects of child life.

In the fiscal year 1947, 234,000 letters came to the Children's Bureau. Many could be answered with a publication; others needed, and got, the personal attention of the Bureau's experts.

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During the fiscal year 2,100,000 publications were sent out in response to requests. The great majority were the Bureau's well-known bulletins for parents. More than a million copies of "Infant Care" were requested from the Bureau, and another 397,000 were sold by the Superintendent of Documents. From 1914, when the first edition of this bulletin was brought out, to the end of June 1947, more than 20½ million copies had been distributed. Requests during the year for free copies of "Prenatal Care" totaled 232,100 and for "Your Child From One to Six," 237,000. The Bureau issued 35 new and 14 revised publications.

As one way to report to the people what it knows and to learn from the people what they want from public service, the Bureau has always kept in close uch with the many National, State, nd local groups concerned with the elfare of children. During the war, aders from many of these groups ormed a national body, known as the ational Commission on Children in Vartime. This organization was imensely valuable in counseling the ureau and in focusing public attention n the needs of children under war ressures. In December 1946 the Comission reconstituted itself as the Naonal Commission on Children and outh and voted to continue as a body dvisory to Federal agencies and to citien groups supporting programs for hildren and youth. Members are apointed, on advice of the Executive ommittee, by the Commission's chairian and by the Chief of the Bureau.

At its first meeting in December the ew Commission adopted an "Action Program for 1947 and 1948." This acon program emphasized again the eed for expansion of social-security rograms affecting family income; hild-welfare and child-health services; ederal and State aid for education; nental-health and guidance programs; ecreational opportunities for children; nproved child-labor legislation and mployment opportunities for boys and irls ready to start work; State and ommunity planning for children and outh, with youth participation in the lanning; and international action to trengthen services for children and outh in all countries. The Commision strongly recommended that a 1950 White House Conference on Children e held and that in anticipation States nd local communities measure the rogress made since the last conference nd, on that basis, determine problems hat need to be taken up at the 1950 onference.

Grants-in-aid programs

The three programs for maternal and child welfare under the Social Security Act are substantial expressions of the principle that only through the sharing of responsibility by Federal, State, and local governments can the Nation's children be assured of their right to a good start and a fair chance in life.

Title V of the Social Security Act authorizes annual appropriations for grants to the States to improve and extend their health and welfare services for mothers and children. Under the amendments of 1946 these grants are $11,000,000 for maternal and child health services, $7,500,000 for services for crippled children, and $3,500,000 for child-welfare services. All 48 States, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands receive grants for all three programs. The Virgin Islands were brought under coverage of the act, as of January 1, 1947. The 1946 amendments marked the second time that grants had been increased. In 1935, when the act was passed, they totaled $8,150,000. That sum was stepped up to $11,200,000 in 1939 and to $22,000,000 in 1946.

Unlike the insurance and public-assistance programs under the Social Security Act, which are designed to *strengthen a family's economic security* by furnishing a basic minimum income when earnings are interrupted, the grants-in-aid programs administered by the Children's Bureau are intended to promote and *improve the family's general welfare* through providing public health and welfare services. None of the Federal money under these programs is paid directly to any parent or child. It goes to State agencies to strengthen, extend, and improve the work of these agencies and their counterparts in local communities. . . .

To develop standards of good service, to meet requests from States for advice in the development of their programs, and to work on the many problems involved in reaching children needing care, the headquarters staff of the Children's Bureau includes a wide range of professionally trained people—obstetricians, pediatricians, medical social workers, nurses, nutritionists; a psychiatrist and a psychologist; a dentist, a physical therapist, a hospital-administration consultant; and social workers with special training and experience in child-welfare services, in public welfare administration, in group work, and in foster-home and institutional care of children. In most of the Social Security Administration regions the Bureau has teams of regional workers whom the State agencies can consult about their federally aided programs. Owing to inadequate funds, some regional staffs are incomplete. Advisory committees in various technical fields assist the Children's Bureau in developing policies relating to the administration of grants in aid. . . .

Immediately after increased funds were appropriated by Congress in August 1946, the Bureau called together its advisory committees to make recommendations on how the States might best improve their health services for mothers and children. The State and Territorial Health Officers' Association was another source of guidance in developing these Federal-State programs. It was agreed that increased effort should be put into (1) extending or developing new programs for children with rheumatic fever, cerebral palsy, hearing defects, and other crippling conditions; (2) demonstrating school health service projects in selected areas; (3) increasing development of maternity-care programs; (4) increasing and improving facilities for care of prematurely born infants; (5) developing medical and dental care programs for children; and (6) promoting mental-hygiene programs for children.

Maternal and child-health services

In all States, maternal and child-health programs are administered by State departments of health, through divisions or bureaus of maternal and child health. In 40 States, such divisions are directly under the State health officer. Other States vary in their administrative organization.

The function of the State division or unit is to develop and provide, with the help of local health departments, Statewide health services for children from birth through school age, and for mothers before and after childbirth. The staff may include obstetricians, pediatricians, psychiatrists, psychologists, dentists, nutritionists, public-health nurses, medical social workers, and health educators; a physician is in charge. Through financing postgraduate education and through consultation, the division helps professional workers in private practice or public service to improve the care they give mothers and children.

Services provided by local health departments are primarily for the promotion of health and the prevention of illness. Many health departments also furnish medical, dental, nursing, and hospital care to a limited number of mothers and children, in special circumstances or in particular areas.

Notable progress was made during the year in extending the range and increasing the coverage of maternal and child-health services. Services traditionally thought of in connection with an essentially preventive and health-promotion program, such as prenatal clinics, well-child conferences, and public-health-nursing services, were increased.

Personnel strengthened

Thanks in large part to the additional funds, there was a general strengthening of medical and other personnel in the State programs. Medical positions in the fiscal year 1947 totaled 185, as against 130 in 1939. Most of the States, with the approval of the Children's Bureau, gave high priority in their budgets to graduate training for their staffs. In 1946–47, State agencies planned to spend approximately $1,000,000 of their total maternal and child health funds on professional training. In the development of in-service training programs, the granting of educational leave, and the planning of training courses for physicians, psychiatrists, psychologists, dentists, nurses, and medical social workers and psychiatric social workers, the Bureau has collaborated closely with the States.

Institutes for nurses in pediatric and obstetric instruction were held in various States during the fiscal year. The Bureau's orthopedic, physical-therapy, and regional nursing consultants participated in an orthopedic workshop conducted by Colorado for public-health nurses. Substantial grants, approved by the Bureau, were made by State agencies to a number of universities for clinical courses in obstetric and pediatric nursing. In May 1947 a maternity-nursing workshop was held under the sponsorship of the Maternity Center Association and the Bureau.

In the field of medical social work, educational and training activities have included consultation with schools of social work in the development of courses in the social aspects of public health and medical care. The Bureau also assisted in developing institutes and seminars for medical-social-work consultants in programs for maternal and child health and for crippled children, held under the sponsorship of various universities.

Six States provided educational leave and stipends for 11 nutritionists for graduate study. The Bureau advised schools of public health and colleges of home economics on their graduate courses of training for nutrition work in the public-health field.

In spite of new staff appointments and the efforts made by the States to recruit professional workers many staff vacancies still existed in many States at the close of the fiscal year 1947. Low salary scales for some public-health positions make recruitment of qualified workers difficult. In all States, shortages of physicians trained or experienced in public health, obstetrics, or pediatrics handicap the development of maternal and child health programs.

On January 1, 1947, at least 2,489 vacancies existed in public-health-nursing positions for which budgetary provision had been made, though 750 more public-health nurses were employed than a year earlier. Of the approximately 150 positions for nutritionists included in the annual budgets of the States, about 1 in every 4 was unfilled. The supply of medical social workers is still limited for the 144 positions budgeted in the maternal and child health programs.

The number of mothers who received antepartum medical services increased from 117,000 in 1945 to 129,000 in 1946, but the number receiving antepartum public-health-nursing services decreased from 238,000 to 231,000. Approximately 31,000 women were given postpartum medical examinations in 1946, as compared with 35,500 in 1945; some 203,000 received postpartum nursing services in 1945, compared with 201,400 in the previous year.

About 456,000 infants and preschool children attended well-child conferences in 1946, as against 426,000 children in 1945. Public-health-nursing services reached about 952,000 infants and preschool children, somewhat fewer than in 1945.

Physicians' examinations of school children numbered 1,587,000, as compared with 1,117,000 in 1945. The number of public-health-nursing visits for school health supervision increased from 2,166,000 to 2,184,000.

Nearly twice as many immunizations for smallpox were given—2,457,000 in contrast to 1,273,000 in 1945. Diphtheria immunizations increased from 1,360,000 to 1,452,000.

Dental inspections of school and preschool children by dentists or hygienists showed a substantial gain in volume in 1946, when they totaled 1,143,000 as compared with 788,000 in 1945.

The foregoing figures, on services for the calendar year 1946, cover the first half of the fiscal year 1947. Since the increased Federal grants did not become available until the fall of 1946, the figures do not reflect fully the gains made possible with the increased appropriations.

Crippled children's services

All States have legislation authorizing an official State agency to provide treatment of and care for crippled chil-

More school-age children were immunized against diphtheria in 1946 than in 1945.

dren. In 31 States, the agency is the State health department: in 10 it is the department of public welfare: in the remaining 12 jurisdictions other agencies are used. In its consultations with State agencies, the Children's Bureau, though recognizing the right of the States to work out their own machinery, has stressed the advantage of unified administration of the programs for maternal and child health and crippled children.

Trained homemakers are employed more and more by both public and private agencies to care for children in their own homes while the mother is ill or is absent from the home.

Through their crippled children's agencies, States seek to provide services that include locating all crippled children; diagnosing their crippling conditions; maintaining a register of all crippled children in the State; providing or locating skilled care for crippled children in hospitals, in convalescent and foster homes, and in their own homes; and cooperating with agencies and professional groups concerned with the care and training of crippled children.

Services are State-wide but because of limited funds relatively few States are able to care for all the crippled children within their borders. Nevertheless, with enlarged Federal grants, definite progress is being made in getting more services to more children.

At the close of the calendar year 1946 State registers of crippled children included the names of more than 442,000 children, an increase since December 1945 of about 38,000. A child is eligible for registration if he has a type of crippling for which, according to the approved State plan, children may be accepted for care by the official State agency, and if the crippling condition has been diagnosed by a licensed physician. A beginning was made during the year, with the assistance of the Bureau's Advisory Committee on Crippled Children's Statistics, on a review of the purposes and uses of the crippled children's registers.

Reports by State agencies show increases in the calendar year 1946 in the volume of all types of services. More than 108,000 children received diagnostic or treatment service at crippled children's clinics, as compared with about 93,000 in 1945. More than 27,000 children received hospital care, and 4,700 received care in convalescent homes. Approximately 1,300,000 days of care were provided in hospitals, and 478,000 days in convalescent homes.

The kinds of services also have been added to. During the fiscal year, Arizona and Hawaii initiated special programs for children suffering from rheumatic fever and rheumatic heart disease, bringing to 22 the number of States operating rheumatic-fever programs. Most of these programs have included complete care, including medical, nursing, and medical-social-work services; diagnostic and treatment services; care in hospitals, sanatoriums, or convalescent homes; and aftercare to safeguard medical gains and help the child's adjustment.

Polio victims numerous

Of all crippling conditions represented on State registers of crippled children, poliomyelitis ranks first. In the calendar year 1946, more than 25,000 cases of acute poliomyelitis were reported, as compared with 13,500 in the preceding year. States in the North Central region, the Rocky Mountain area, and the Far West experienced the highest incidence of the disease.

State directors of programs for crippled children are showing increasing interest in services to children with cerebral palsy. This group of children has consistently ranked second to those with poliomyelitis on State registers. At the present time more than 40,000 such children, nearly 10 percent of the total number on the registers, are known. Since 1937, at least 6 States have carried on special programs for children with cerebral palsy. At the end of the fiscal year 1947, 12 States had special programs for these children, and 7 more were planning such services for the coming year.

Among groups of parents and influential lay organizations, there is a rising tide of interest in cerebral palsy. The National Society for Crippled Children and Adults has recognized the value of this spontaneous lay interest and has organized advisory councils and other services to provide national leadership.

The Children's Bureau, in March 1947, called together a conference of medical specialists and professional persons from related fields concerned with the care of the child with cerebral palsy. This conference, the first of its kind, drew up recommendations to be used as guides by the Children's Bureau and by State crippled children's agencies in getting work started in behalf of these neglected children.

One additional State in 1946 extended its services for crippled children to provide care and treatment of children with hearing defects; 5 States now have such programs. About 20 States make some provision for surgical correction of visual impairments.

Demonstration projects financed with Federal funds in the fiscal year 1947 are making progress. Maryland provided surgical treatment for children with heart disease. The District of Columbia started general pediatric care for children who were chronically ill. Maine established a special plastic-surgery program. The Alaska Territorial Health Department put into operation the first hospital for crippled children in the Territory, eliminating the need to send all such children to Seattle for hospital care.

Many of our children are fortunate enough to enjoy facilities for recreation like these.

Child-welfare services

In every community there are children in trouble. The trouble may be caused by parents' illness, death, inadequacy, ignorance, or neglect. It may be due to lack of good community resources and safeguards for all children. It may trace back to other factors detrimental to the development of emotional security and good social relations.

These children may be living in their own homes, in foster homes, or in institutions. They may be children of illegitimate birth, or children needing legal protection of their person or property. Their need for help may be reported by parents, other relatives, neighbors, teachers, police, judges, or other community workers.

These are the children for whom the welfare agency of each State has created special child-welfare services. These services are provided usually by a local welfare department under the general supervision of a child-welfare division of the State department of public welfare. Child-welfare staffs of local and State welfare departments include professional social workers with training and experience in the problems of children in need of special care and service.

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Child-welfare services provided in communities can be described best by listing the types of service given in various localities. These services, which all require the skills of qualified social workers, are (1) counseling on problems of children in or out of their own homes; (2) arranging for foster-home or institutional care for children who need care away from their own homes, either temporarily or permanently; (3) finding and securing the necessary attention for children who have physical, mental, and emotional handicaps and who are not receiving the care they need; (4) safeguarding children of illegitimate birth; (5) assisting courts handling children's cases; (6) cooperating with State institutions caring for children; (7) working with mental-hygiene clinics; and (8) assisting schools in handling attendance and conduct problems. Child-welfare workers also help organize community services for children, including services for the prevention of juvenile delinquency.

Soon after Congress made available the increased grants, four regional conferences with State public welfare administrators and directors of child welfare were held to discuss directions the expanded programs might take.

Local, State, Federal resources

At these conferences there was general agreement that the States have a responsibility for seeing that services are provided for all children, irrespective of sex, race, creed, residence, or economic status. Strong evidence was presented that local welfare agencies cannot provide adequate care and facilities without State aid, and that Federal funds are needed to strengthen State resources. An acute shortage of qualified workers is one of the most serious problems confronting all social agencies.

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The full time of a special consultant on the Children's Bureau staff is devoted to advising the States on staff development, methods of training, policies of educational leave, cooperation with schools of social work, and recruiting problems. A Nation-wide survey has been made of the recruiting methods used by State welfare agencies, and an appraisal of the relative merits of such methods is being prepared for the use of these agencies. A subcommittee of the special committee on training and personnel, advisory to the Children's Bureau and the Bureau of Public Assistance, was of major assistance in formulating policies on educational leave and field-work placements.

The regulation which prohibited the use of Federal funds by the States in paying for the maintenance of children in foster care except in certain emergency situations was revised during the fiscal year to allow these funds to be used for the temporary care of children in boarding homes or care in such homes for special groups of children with particular needs.

Services increase

Approximately 230,000 children were receiving noninstitutional services from public child-welfare agencies on December 31, 1946, an increase of about 5 percent over the number a year earlier. Of every 5 children receiving such services, 2 were living with parents or other relatives, 2 were in foster-family homes, and 1 was in an institution or elsewhere.

As of June 30, 1946, there were slightly more than 2,200 full-time child-welfare workers paid from public funds. In addition, 663 other employees were devoting full time, and

Other children seek recreation wherever they can find it, often in undesirable places.

2,981 part time, to child-welfare programs.

Emergency maternity and infant care program

Unlike the regular maternal and child welfare programs under the Social Security Act, which require State financial participation, the special wartime program for emergency maternity and infant care has been financed entirely by the Federal Government from its general tax revenues. Liquidation of the program started on July 1, 1947.

Launched by unanimous vote of Congress on March 18, 1943, the emergency maternity and infant care program has proved to be the biggest public maternity-care program ever undertaken in this country. The Children's Bureau has been responsible for its Federal operations.

Under the program, the Federal Government undertook to provide maternity care for wives of enlisted men in the lowest four pay grades of the armed forces and of aviation cadets, and to provide medical, nursing, and hospital care for their infants during the first year of life. Care provided was without cost to the serviceman's family.

From the start of the program through June 30, 1947, a net total of $124,900,000 had been allotted to the States to cover the cost of care and State administrative expenses. More than 1,420,000 cases had been completed or approved for care.

State health departments administered this program, and to them large credit must go for the efficient operation of the huge undertaking. The many private physicians and hospitals providing care also merit the Nation's gratitude, for without their skills and service the program could not have been carried out. At its peak in 1945, 48,000 physicians and 5,000 hospitals were cooperating. These figures represented 50 percent of all active physicians in private practice at that time, and 90 percent of the registered hospitals other than those caring for mental, nervous, and tubercular patients.

With the close of hostilities in 1945 and the end of Selective Service in March 1947, the need for an emergency maternity and infant care program lessened. Only 152,000 new cases were authorized in the fiscal year 1947, of which 100,000 were maternity cases and 52,000 were infant cases. The year before, approximately 385,000 new cases had been authorized, while in the fiscal year 1945 the number authorized was about 484,000. In the last 6 months of the fiscal year 1947 the number of infant cases represented 41 percent of all authorizations, as compared with 11 percent in July–December 1944. At the close of the fiscal year the States were carrying about 106,000 uncompleted cases.

In liquidating the program, all cases authorized before July 1, 1947, will be completed. New cases may be accepted thereafter only if they were otherwise eligible for care as of June 30, 1947. It is anticipated that care for the last case will be completed within the 2 years between July 1, 1947, and June 30, 1949. Congress has appropriated $3,000,000 for that period.

International cooperation

Together with 21 other Government departments and agencies, the Children's Bureau is cooperating in the program of the Interdepartmental Committee on Scientific and Cultural Cooperation under two acts of Congress relating to international cooperation. Member agencies of this Committee receive a special budget from the Department of State for their activities under these provisions.

Under this program of international cooperation, the Children's Bureau lends other American Republics, on request, the services of its consultants in child health and child welfare for limited periods. It also assists specialists from other American Republics in planning and carrying out studies and observations of child health and welfare services in this country.

During the fiscal year 1947 the Bureau assigned a medical consultant, a nutrition specialist, nurse-midwives, and child-welfare workers to work with government agencies in Argentina, Brazil, Colombia, Costa Rica, Ecuador, Guatemala, Mexico, Panama, and Peru. In some instances this staff gave advisory service in the maternal and child-welfare programs of these countries; in others they helped governments develop training programs for professional workers. . . .

Four specialists from Bolivia, Mexico, Panama, and Paraguay received grants to study child health and welfare services in the United States in the fiscal year 1947. Their schedules in this country were worked out by the Children's Bureau. Similar guidance was given to more than 200 visiting specialists from countries in other parts of the world who were referred to the Children's Bureau by the U. S. Department of State, United Nations agencies, and individual foreign agencies.

Child-health and social problems in border communities were studied at two conferences held in Laredo, Tex., and San Diego, Calif., in May and June

1947, respectively, under auspices of the Mexico-United States Border Health Association. Children's Bureau representatives attended.

The Chief of the Children's Bureau, who is the official United States representative on the council of the American International Institute for the Protection of Childhood, was represented at its meeting in Montevideo, Uruguay, in April 1947. Plans were made at this meeting for the Ninth Pan American Child Congress, to be held in Caracas, Venezuela in January 1948.

To appraise maternal and child welware needs in the Philippines, the Bureau sent a medical consultant and a psychiatrist to the Islands for several months to make observations in cooperation with agencies of the Philippine Government.

Assistance was given the United States Committee for the Care of European Children, responsible for placing unaccompanied children who enter the United States under authorization of the President's directive of December 22, 1945. These placements are made under the supervision of social agencies designated by the Children's Bureau.

Various conferences were held on problems arising from the presence of United States troops in other countries. These relate to questions of paternity, claims for support, and petitions for adoption of children who were born out of wedlock and whose alleged fathers were members of the United States armed forces.

The Chief of the Bureau was appointed to serve as alternate to the United States representative on the Temporary Social Welfare Committee of the Social Commission of the Economic and Social Welfare Council of the United Nations. The Bureau's chief was also appointed as United States representative on the Executive Board of the International Children's Emergency Fund, established to assist in the rehabilitation of children of war-torn countries and for child-health purposes generally. The Associate Chief of the Bureau was appointed Chief Medical Consultant for the International Children's Emergency Fund of the United Nations and visited a number of European countries in connection with planning the program. The Associate Chief also was vice chairman of the United States Delegation to the International Health Conference, which formulated the constitution of the World Health Organization.

A look ahead

From looking backward at the record of achievements, we must turn to look forward at the job still to be done for the children of the Nation.

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Much of the evidence of need for services was presented to the Seventy-ninth Congress, which increased the Federal grants to $22,000,000. Additional testimony was presented to the Eightieth Congress in hearings on the National Health bill, the National Health Insurance and Public Health bill, and the National School Health Services bill.

Further documentation of the need of great numbers of children for a better chance in life was strikingly presented in "A Program for National Security", the report of the President's Advisory Commission on Universal Training, submitted on May 29, 1947.

"The factors that make an individual fit or unfit to defend his country," the report states, "are many years in the making; when an emergency comes, relatively little can be done to remedy his past lacks and present deficiencies." After an illuminating summary of some of the available information on how far we have "actually come in making sure that every child has what all children need," the report concludes that "the children that represent the majority of our future citizens—country children, children in low-income families, and children in minority groups—have a disproportionately small share in resources, safeguards, and opportunities that all children need. Now, as in the past, our cities and industries look to rural areas and low-income groups for population growth, for the development of production, for markets. The handicaps that many American children face in health, nutrition, education, and housing, and the inadequacies in community services and safeguards for children must concern the whole Nation."

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There are some 3,100 counties or equivalent jurisdictions in the United States. Two out of five do not have the service of a full-time public-health unit; one out of three has no public-health nurse. Three out of five rural counties have no regular maternity clinics; two out of three have no well-child conferences. Twenty-five States have no child-guidance clinics in any community. Approximately five-sixths of all the counties have no full-time child-welfare worker paid from public funds. Present workers are most unevenly distributed among the States, and between rural and urban areas. In no State or city of the country is there complete coverage by well-rounded, well-developed programs of child-welfare services.

Research is the cornerstone of an efficient program of services for children. Compared with the widespread research, publicly financed, into the development of plant and animal life, relatively little is done in the field of child growth and development. Many research projects that could be carried out best on a national scale cannot be undertaken because of lack of funds. Many that could be undertaken by public and private agencies in the States and communities also are blocked by insufficient support. Better coordination and interchange of information is needed to multiply the usefulness of the research now going on.

1950 White House Conference

It has become a tradition in the United States every 10 years to assess the condition of children and to measure the distance we have come in providing them with opportunities for wholesome growth and development. This has been the function of the White House Conferences on children. The first was held in 1909; the fourth, in 1940. It is time, now, to plan for a 1950 White House Conference.

Just as we have learned that the welfare of a few children in a community cannot be assured unless all children in the community have the same assurance, so it is with the children of this Nation and of other nations. There must be increasing opportunities for cooperation in matters of concern to children, both between individual governments and through international channels, particularly the United Nations and its special agencies.

Reprints available in about 5 weeks

Care for Rural Mothers

(Continued from page 99)

cluding Rh typing and antibody titering, if indicated; chest plates: and X-ray pelvimetry where indicated. Each patient, whether a patient at a clinic or of one of the local physicians, falls into one of three groups, and her further care largely depends on which group she is in. She is either entirely normal, or presents borderline abnormalities, or presents one or more major abnormalities.

If pregnancy is, and remains, normal the patient will receive delivery care in one of four ways, depending on her own desires and the local facilities available. She may choose her physician for home delivery, provided that the physician will accept her for this: or she may choose her physician for hospital delivery; or she may be enrolled on the home-delivery service of the certified nurse-midwife, in the areas where they are present; or she may engage one of the granny midwives to deliver her at home. This last type of care, of course, is the least desirable.

In those cases presenting borderline abnormalities, such as mild degrees of contracted pelvis, borderline chronic hypertension, and so forth, the patient is seen and evaluated by the obstetric consultant. Together with the deputy State health officer, nurses, and the local physician he takes steps to arrange for the patient's proper care locally. This usually means hospital delivery under the supervision of one of the local physicians, who, in turn, knows he can call upon the consultant for aid and advice if things do not progress satisfactorily.

It is among the patients having major obstetric complications that the greatest good can be done. Those are the patients who will get into serious difficulty unless they receive expert obstetric care. They are likewise seen by the consultant, who verifies, to the best of his ability, the existence of major deviations from the normal.

If the patient lives in an area near one of the better-equipped local hospitals where there is a physician qualified to deal with major abnormalities, the consultant works out with this physician a plan of therapy for the patient. In those areas where there are no adequate hospital facilities or adequately trained physicians, the consultant refers the patient to a Baltimore hospital for further obstetric care.

During 1946, 140 patients presenting major complications of pregnancy were referred to one of the teaching hospitals in Baltimore from the counties of Maryland. Of this number no mothers were lost and only two infants. These patients were made up of those with previous Cesarean section, severe preeclampsia, eclampsia, extreme degrees of contracted pelvis, heart disease, and the like, and it is easy to imagine what the outcome might have been had they been in the hands of a granny midwife or a physician with meager obstetric training.

Lest I have given the erroneous impression that Maryland has completely solved the problem of furnishing adequate maternity care to all its mothers, it must be admitted that such is by no means the case. We feel that we have set up a workable scheme to insure that every pregnant woman in the State can, if she and her physician desire it, obtain proper care, but to date these facilities are being used by only a very small percentage of those who need specialized care.

The reasons for this are not difficult to discover. First of all, the patients themselves often do not cooperate, failing to secure medical attention until they are in serious difficulty. Private patients are sometimes reluctant to avail themselves of the free services of the health department. In many instances the physician does not wish, for one reason or another, to take advantage of what is available. Some physicians are definitely opposed to the health-department activities and feel that these are an unwanted entrance into their private domain. Others consider themselves quite capable of dealing with difficult obstetric problems and resent any implication that they need help. And so, although the machinery for furnishing good care exists, it can be said quite frankly that to date it is being used sparingly by the local physicians for their private patients. The clinic patients, however, derive the full benefit whenever they are willing to cooperate.

In spite of the obstacles noted, progress is being made. The time is rapidly approaching when one or more additional full-time obstetric consultants will be necessary to handle the increasing volume of work. The fact that one person has been able to carry the load thus far is proof of the meager use of his services, but the load is becoming heavier as the months go by.

In summary, then, Maryland has over the past 19 years gradually evolved a maternity program which today makes it possible for every pregnant woman in the State to receive adequate obstetric care, irrespective of her financial status, color, or creed. Utilizing a full-time staff composed of general-staff nurses, deputy State health officers in every county, certified nurse-midwives when obtainable, a public-health-nursing consultant in obstetrics, and a full-time obstetric consultant, it is possible to provide expert care to all. Every effort is made to obtain the cooperation of local physicians and to cooperate with them. A close association with a teaching hospital in Baltimore provides facilities for specialized care not available in rural areas.

Until such time as something better comes along, we plan to enlarge along the present lines. To bring the plan to success will require constant education of patients to avail themselves of existing facilities, and equally constant education of the practicing rural physicians.

Reprints available in about 5 weeks

• CALENDAR

Jan. 26–27—Annual meeting—National Conference on Social Welfare Needs. National Social Welfare Assembly, Washington, D. C.

Jan. 28–30, 1948—National Commission on Children and Youth. Washington, D. C.

Feb. 4—National Social Hygiene Day. Further information from the American Social Hygiene Association, 1790 Broadway, New York 19, N. Y.

Feb. 6–7—National Conference on Rural Health, American Medical Association. Chicago, Ill.

Feb. 8—Negro History Week. Association for the Study of Negro Life and History, Inc., 1538 Ninth Street NW., Washington 1, D. C.

Feb. 26—National Committee for Parent Education. Atlantic City, N. J.

NORWEGIAN SCHOOLS OFFER HEALTH SERVICES TO CHILDREN

ANNA KALET SMITH *International Cooperation Service, U. S. Children's Bureau*

HALF A CENTURY has passed since the first physicians were employed in the city schools of Norway. Introduction of physicians in the rural districts has been retarded by the sparsity of Norway's 3-million population, which makes it necessary for school physicians to cope with difficult transportation over long distances.

The urgent need for better health work has been widely recognized, however, and in 1935 and 1936 laws were enacted requiring employment of physicians in all city elementary and secondary schools, and in rural schools whenever the money was available.

Physical examinations

In consequence, the director of school health in Oslo was able to report early in 1947 that children were regularly examined by physicians in all schools of the country, but the extent of the health work varied with the size of the school and other circumstances. In some places the examinations are limited to children entering school, those for whom reexamination was recommended by the school physician at the time of the first examination, and those referred to the school physician by the teacher because of illness.

The school health services in Oslo are typical of those offered in the larger cities. Each child receives a thorough physical examination at the beginning and the end of the school year and oftener when necessary. The physician examines children who have been absent a week or more on account of illness and those whom their parents wish to be examined. He also selects children for vacation camps and open-air schools, and advises parents on their children's health.

A tuberculin test is given to every child entering school. Children with a positive reaction are referred to the Tuberculosis Division of the Oslo Department of Health; those with a negative reaction are retested annually.

All children in Oslo are examined by an ear, nose, and throat specialist during their first year at school. An eye specialist examines those referred to him after inspection by a specially trained nurse. Also all boys are tested for color-blindness. An orthopedic surgeon and a psychiatrist examine the children when necessary.

The school physician does not treat the children but refers them to other physicians and, through school nurses, he tries to make sure that his advice is followed.

Every teacher is given an examination for tuberculosis, including an X-ray of the chest, at the time of entering the service and once a year thereafter.

The city of Oslo, population 275,000, has 20,000 children in the public schools, elementary, continuation, and secondary; it employs 30 general practitioners, one of whom is director of school health, 4 specialists, and 15 nurses. Some of the physicians are on part time.

Dental care

Dental care of school children was introduced in Norway in 1910, at first in Oslo, and later in other cities and in rural districts. Much of the early work was done with local public funds.

In 1917 the Norwegian Parliament began to make available grants to those local authorities that undertook to give free dental care to school children; but the results were considered inadequate. Therefore, the cities were directed by a law of 1936 to introduce free dental care in all elementary schools; in rural schools this was to be done whenever funds were provided by the local authorities. Government aid was made available for both city and rural schools.

Most of the urban communes, administrative divisions, have school dental clinics, but only about one-third of the rural communes had such clinics up to 1943.

Dental hygienists have been employed for over 20 years. Their training, as reported by the chief dental officer of the Oslo schools, is patterned on that in the United States.

One of the best systems of dental care in Norway is found in Oslo. Both preventive and complete corrective treatment are given, including extraction, filling, correction of irregular position of the teeth, treatment of diseases of the gums, minor oral surgery, and periodic X-rays. Although attendance at the school dental clinics is optional, 95 percent of Oslo's school children were examined there in the school year 1944–45. Of these, 91 percent were treated; the rest declined treatment. In that year 19 clinics were open every school day, staffed by 20 dentists—14 full time—and 8 full-time dental hygienists.

The city of Oslo also provides dental care for dependent children in institutions near Oslo and to children placed in foster homes in localities that have no free dental care for school children. The foster children are visited by mobile dental clinics. Also, children who attend schools maintained by churches or other organizations are regularly treated in the school dental clinics of Oslo.

Besides giving free dental treatment to school children, the city of Oslo has been since 1939 providing dental treatment at a nominal charge for children between the ages of 3 and 7 and for young people from 15 to 18 years. In this way all residents of Oslo between the ages of 3 and 18 years may obtain continuous dental care.

For persons over 18 free dental service has been available in Oslo since 1942. Every person in the city over 18, who is covered by sickness insurance and who has been under continuous dental supervision in a public or private clinic from the age of 3 until 18, is eligible for dental care without charge. This is of great importance, since sickness insurance is compulsory for two-thirds of the population.

Mental hygiene

At least two psychological clinics, one of them in Oslo, were operating in connection with the public schools in March 1947. Several other cities were planning at that time to open such clinics. They examine problem children and those considered for placement in a special class or school. Approval by a psychiatrist or psychologist is necessary for placing a child in such a class or school or in an institution for mentally defective, wayward, and other problem children.

Psychiatric nurses assist the psychiatrists.

School meals

School lunches were introduced in Norway about 50 years ago. Since 1925 they have been gradually replaced by the famous Oslo breakfasts, originated by Dr. Carl Schiötz, chief medical officer of the Oslo schools. The breakfast, with slight variations, is served free of charge to school children in many parts of the country, mostly in cities and towns. The breakfast is optional and is served, with the parents' consent, to all children, without distinction. In Oslo 90 percent of the school children receive the breakfast.

The breakfast consists of as much whole-rye or other whole-grain bread as the child wishes, with margarine and a kind of whey cheese: also either half an apple, or half an orange, or 2 ounces of raw carrot, alternating every third week; and about a pint of fresh milk. Carrots are used mostly in the fall because they are then cheaper and better. The breakfast is served every school day 45 minutes before class time. Children who eat the school breakfast are instructed to take no food before leaving home.

In Oslo the breakfast is prepared in the municipal central kitchen and brought to the schools. Serving of the breakfast is supervised by teachers who volunteer their services. The children are taught to eat slowly and to observe table manners.

The cost of the meals is met in most cases by the cities, in other instances by private organizations.

An educational campaign has been conducted among parents as to the value of the breakfasts.

Vacation camps and open-air schools

Large numbers of vacation camps for school-age children are maintained in Norway. These camps are for children, below par in health, who are from low-income families. The camps maintained by cities and some private organizations are free. The city of Oslo has maintained vacation camps for nearly 30 years. Early in 1947 the city had 32 such camps, with places for 2,500 to 2,700 children.

In the municipal camps the children are examined by a physician within 2 weeks after arrival and are kept under medical supervision during their stay, which is usually 6 weeks.

In recent years 92 percent of the school children in Oslo have been having vacations in the summer, for at least 3 weeks, at either free or paid camps.

Public and private open-air schools for children exposed to tuberculosis in their families and delicate children who are living under insanitary conditions function the year round in many parts of the country.

• FOR YOUR BOOKSHELF

UNDERSTANDING THE PSYCHOLOGY OF THE UNMARRIED MOTHER. Family Service Association of America, 122 East Twenty-second Street, New York 10. 1947. 32 pp. 50 cents.

Four papers, by Babette Block, Sylvia Oshlag, Frances H. Scherz, and Leontine R. Young, reprinted from *The Family*, now the *Journal of Social Casework*.

ADOPTING A CHILD, by Frances Lockridge, with the assistance of Sophie van S. Theis, Secretary of the Child Placing and Adoption Agency of the New York State Charities Aid Association. Greenberg: Publisher. New York, 1947. 216 pp. $3.

Written for adoptive parents, this book emphasizes the beneficial role of the authorized agency in adoption. It answers many questions of prospective adoptive parents—the steps in adoption, the information needed on adoptive parents and children to be adopted, where the children stay until they are adopted, the probationary period and its purpose. It also shows why there are children in institutions and foster homes who need to be cared for but are not available for adoption.

Psychological testing of infants is discussed briefly.

Comments on the relative importance of environment and heredity are quoted from the staff psychiatrist of the Child Placing and Adoption Committee.

Parental attitudes as a basis for a successful adoption are considered. In addition to the necessity for telling a child he is adopted, the problems connected with giving him knowledge of his background are mentioned.

Improving the parent-child relationship rather than granting abrogations of adoptions is stressed. One chapter is given over to summarizing some of the provisions in adoption laws of the various States.

I. Evelyn Smith

THE HOUSEMOTHER'S GUIDE, by Edith M. Stern in collaboration with Howard W. Hopkirk. Commonwealth Fund, New York, 1946. 91 pp. 1 to 9 copies, 50 cents each; 10 to 49 copies, 37½ cents each; 50 or more copies, 35 cents each.

Children need love, self-confidence, and the opportunity to develop initiative; they must be understood and treated as individuals with individual differences; meeting their needs, emotional as well as physical, is the most important part of the job; and their life in an institution must not only be satisfactory in itself but also prepare them for life in the world later. These are the principles that this pamphlet aims to help housemothers in institutions to carry out.

The pamphlet points out the fact that the essential part of the housemother's work is not so much to maintain orderliness and mannerliness and regularity of habits and obedience, as it is to provide understanding and affection. It emphasizes that housemothers should never expect thank-yous; that good mothers never demand gratitude, and neither should good mother-substitutes; and that to express appreciation is a part of adult, not of childish behavior.

Much of the material relating to handling problems of children outside their own homes and relationships to their parents would be helpful also to foster mothers.

I. Evelyn Smith

DELINQUENT GIRLS IN COURT; A study of the wayward-minor court of New York, by Paul W. Tappan. Columbia University Press, New York, 1947. 265 pp. $3.

●

Our January cover picture shows a proud granddad and a radiant granddaughter, photographed by Clifford J. Hynning.

Credits for other photographs:

Page 99, left, Virginia State Health Department; right, E. S. Powell for South Carolina State Board of Health.

Pages 100 and 106, Federal Works Agency.

Page 102, Philip Bonn for U. S. Children's Bureau.

Page 104, New Mexico State Department of Public Health.

Page 105, Social Security Administration.

Page 107, Federal Public Housing Authority.

FOR OUR CHILDREN'S FUTURE

As a Nation we have much unfinished business to do for our children, as is pointed out by the thirty-fifth annual report of the Children's Bureau, outlined in part in this issue of *The Child.*

Despite the high level of medical care in this country, we are doctor-poor. Particularly is this true in rural areas. Only 4 percent of our pediatricians are in places of less than 10,000 population, where 60 percent of our children live.

What are we going to do to bring these rural children within reach of doctors, hospitals, diagnostic clinics?

Every State now has specialized health and welfare services for children, but no State has services sufficiently well staffed to serve all children needing help.

What are we going to do about the counties—two out of every five—that lack a full-time public-health unit?

What are we going to do about the one-third of our counties that have no public-health nurse; the three out of four rural counties with no regular maternity clinic; the two out of three rural counties with no regular monthly well-child conferences?

We have reduced the infant mortality rate for the Nation to 38 per 1,000 live births, but what are we going to do for the 21 States whose rate is above that figure?

For the Nation as a whole, we have reduced the maternal mortality rate to 21 for every 10,000 live births. But what about the 20 States which lose more mothers than that?

We know that one out of every three deaths in the United States is due to diseases of the heart and blood vessels, and that rheumatic fever, including rheumatic heart disease, causes much of the heart disease in later life.

The care of many children attacked by this disease is a public-health problem, because their care is expensive and long-drawn-out. Twenty-two States have programs for the care of children with rheumatic fever or rheumatic heart disease. What about the other States?

We have some 500,000 children with orthopedic defects—clubfoot, harelip, cleft palate, and other handicaps—which are sometimes serious emotional handicaps as well as physical ones. Some of these half-million children are being cared for under State crippled children's services. But every State knows of crippled children who are forced to go without care because the State is unable to supply it.

The list of physically blighted children goes on. Some 170,000 have cerebral palsy, and at least 70 percent of these could be educated and trained to live useful, satisfying lives. We have almost nothing to offer them in public programs, and yet the cost of the training and care they should have is beyond the reach of many of their parents.

Our schools, year after year, find children with defective hearing, with bad eyesight, with bad teeth. We send them home with notes, urging their parents to do something about Johnny's bad teeth and Mary's poor eyes, knowing full well that in most cases their parents, reading the notes, can only worry some more.

We are concerned about our juvenile delinquency, knowing that a child in serious difficulty with the law is an unhappy, maladjusted child needing special attention. We have child-welfare workers to help these and other children with special needs, such as children born out of wedlock, but we have only 2,200 such workers for the whole country.

We have much more to learn about the physical and emotional growth of children. Research and action must go hand in hand.

The question that faces us is simply this: How deeply do we care about moving ahead on these unsolved problems?

Oscar R. Ewing

OSCAR EWING
Administrator
Federal Security Agency

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FEBRUARY · 1948

the CHILD

YOUTH AND THE EMPLOYMENT SERVICE

MAR 3 1948

ROBERT C. GOODWIN,
Director, U. S. Employment Service

EACH YEAR more than a half million boys and girls join the labor force.

These youths include our future artisans, merchants, and professional groups. They are the leaders of tomorrow. The future of our economy and political existence rests in their hands. Let no one tell you that because they constitute such a small fraction of our labor forces they are unimportant. They and other youths who will join their ranks will constitute almost a third of our labor force 10 years hence.

What in general are the characteristics of these entrants? During the past year new entrants in the labor market have included a high proportion of veterans, youths who have had their civilian careers interrupted by military necessity. Some of these, because of aptitude, interest, or other abilities, have received training that will be vocationally useful in their civilian work. Others have been trained primarily in the art of war and find that they have to start anew upon returning to civilian life. Some of the veterans have not immediately entered the labor market, but have taken advantage of the benefits of the Servicemen's Readjustment Act. One million, one hundred thousand are enrolled in our schools to complete their interrupted training. These will be entering the labor market during the next several years. That 11,310,000 World War II veterans have found gainful employment speaks well of the resourcefulness of our country.

Will newcomers keep jobs?

During recent months we have been in a period of high national employment. Close to 57 million people are now working. Seasonal employment in agriculture is on the upswing. But the demand for workers in nonagricultural employment has slowed down. The big question now is whether employment expansion in such lines as construction, agriculture, and food processing will overcome the slack which is beginning to appear in other segments of our economy.

The maintenance of high national employment is essential, not only for high production and prosperity, but for the proper placement of veterans, youth, and other entrants into the labor market. If employment slacks off as a result of soft spots in our economy, veterans and young people will be the hardest hit. They are the workers of least experience and the least seniority, and in general will be the first to lose their jobs.

Like many others, Bill left school for a good job. But times change, and now his job isn't much.

The youth entering the labor force in the next few months will come primarily from the schools. Some will be graduates and some drop-outs. Many will be untrained and undisciplined in the world of work. Some will have learned (or will quickly learn) simple skills that fit them for immediate employment. Because of the temporary economic advantages of employment in occupations requiring little skill, many of these new workers will find employment that will not lead progressively to better paying jobs.

It is this group that offers a special challenge to the public employment service. It is of the greatest importance that these new entrants into the labor force be directed to employment that will consistently and constructively use their potential capacities. In cases where they fail to get off to a good start, the Employment Service must assist them to shift out of blind-alley jobs into occupations with a future.

In approaching the employment of nonveteran youth, we must clearly recognize that school graduates and drop-outs will force increasing competition for future jobs. The backlog of youth who left school during the war and accepted the best-paying jobs (the ones in which they were most needed in the war effort) will face special problems in making a permanent readjustment. The veteran youth, still to be demobilized, will also have special problems in that they are older than the usual new entrants into the labor market. Some of them have married, or will marry

Excerpted from speech made at the thirty-fourth annual convention of the International Association of Public Employment Services, held May 26–29, 1947, at New York City.

in the near future, and they carry additional responsibility not usually attached to the entry worker. The plan for serving youth must be based upon accurate knowledge concerning the needs of the entire group and in addition be geared to the varying needs of the individual.

If a youth program is to succeed, local employment offices, in addition to providing placement and employment counseling services, must assume leadership in organizing community facilities to advance the employment interests of young people. Specifically, local employment offices must provide information to training agencies on employment trends and the requirements of occupations to assure the development of training programs geared to the needs of the labor market; they must supply tools and information to the schools and other agencies useful in providing realistic vocational guidance; they must provide information on occupational requirements and opportunities to student and teacher groups prior to graduation; they must develop an understanding by the students, teachers, and other community groups of service available to youth in the local office; they must secure from the schools and other agencies information needed for counseling and placement to supplement that provided by the applicant; and they must assist employers in identifying entry occupations and promoting their acceptance of beginning workers.

To assure that each local office program is realistically geared to the needs of the community it serves, periodic analyses of the number and characteristics of young applicants seeking work through the employment office should be supplemented by a similar study of those leaving school. On the other side, the employment office will need to know how the job openings available in the community compare with the qualifications and requirements of young jobseekers.

Important among our resources for assisting youth is our vast supply of sound occupational and economic information. We have made vast strides in these fields during the war years. We have established a body of materials and experience which will stand us in good stead in assisting youth in resolving their employment problems in the years to come. On the basis of current labor market information we are able to assist young people in relating their interests and aptitudes to current and potential job opportunities, in order that they may avoid the pitfalls which are inevitable if sound information is lacking.

Ida is fortunate to have found steady employment soon after she graduated from high school.

One of our newest tools for assisting youth in selecting and finding employment which will take full advantage of their interests and aptitudes is the general-aptitude test battery, currently being introduced into the 1,800 local offices. With this new aptitude test battery it is possible to analyze aptitudes in relation to 2,000 different occupations. Scores made on these tests by young people seeking guidance can be compared with the scores made by successful workers in 20 different fields of work. The probability of the youth's succeeding in each field may be accurately evaluated.

Students discuss employment

There is one other phase of community counseling activities which, though still in an experimental stage, I should like to mention briefly. Its objective is to effect the fullest possible gearing together of school guidance activities and the employment counseling function of the public employment service. Many communities are experimenting with programs which hold considerable promise. Briefly stated, these programs provide that, during the junior and senior years of high school, the school holds group discussions which explore in rather general categories the so-called "world of work." These divisions separate into the white-collar occupations, including clerical and sales activities, the trade and service fields, and the industrial field subdivided into skilled, semiskilled, and unskilled categories. During the study of each of these divisions, the local employment office, represented by a labor market analyst, an employment counselor, or a placement interviewer, is requested to provide information covering the kinds of jobs found in each of these groups, the basic requirements of these groups in terms of physical capacities or academic background, the general nature of the work and current information concerning supply and demand in these broad fields.

In successive sessions the students are "polled" to see which of the fields represent the greatest interests of the group. These are in turn subjected to more detailed analysis. Again, employment-office personnel are requested to participate, and full use is made of available literature, motion pictures, and other educational aids.

The advantages of such cooperative

(Continued on page 126)

How Can Your Community Plan For the Care of Children in Hospitals?

MARTHA M. ELIOT, M. D.,
Associate Chief, U. S. Children's Bureau

HOSPITALS have had over the years a deep sense of their obligation to render to the community the kind of service it needs.* This concern with what the community needs and wants for its children is also close to the heart of the Children's Bureau.

We have about 42 million children under 18 in the United States—one-third of our population. These children, who hold in their hands the future of this Nation, are the most vulnerable group in their health and welfare needs. The incidence of sickness among those under 18 is higher than for any other age group except people over 64.

But if we are to have healthy children, we must begin with the care that the mother gets during pregnancy. Babies should be born in hospitals where all the facilities for providing the needed care is at hand. We know, for instance, from records of hospitals that have developed services providing medical and nursing care for premature infants, that many infant deaths due to prematurity are preventable.

In 1946 almost 80 percent of the births in the United States were in hospitals, as compared with 37 percent in 1935. States vary a great deal, however, in the percentage of births in hospitals. In 1944, the range was from 98 percent in Connecticut to 31 percent in Mississippi. It is now an established fact that when funds become available to pay for care, and the State and local health departments register the cases and plan with family physicians and hospitals, the percentage of births in hospitals increases. In 1944, in Mississippi, for instance, 73 percent of births under the Emergency Maternity and Infant Care program were in hospitals, in contrast to the 31 percent of all births in the State.

It is difficult, if not impossible, to obtain information on the number of sick children who now receive hospital care.

National medical and health organizations, however, are aware of the lack of information. In order to obtain more specific data, the American Academy of Pediatrics decided in November 1944 to make a Nation-wide study of the health and medical services being given to children. The Academy requested the cooperation of the U. S. Children's Bureau and the U. S. Public Health Service in making this study, which covers four major fields: (1) Pediatric education; (2) distribution and activities of professional personnel; (3) hospital and clinic facilities; and (4) community health services for children. From this study we shall get information on the number of children admitted to hospitals of various sizes in different areas, as well as the number of days of care given to children; and information on the number and qualifications and training of physicians and nurses and others on the hospital staff who care for children. This will provide us with knowledge that we have not had before and that is essential to our planning for the medical and hospital care of children.

Furthermore, data from State surveys of present hospital facilities that will be completed to meet the requirements of the Hospital Construction Act will soon be available. Every effort is being made to combine and correlate this material with the findings of the American Academy of Pediatrics.

We are thus seeing at this time a convergence of effort to get the information that is essential for sound community planning—whether National, State, or local.

I should like to call your attention to another source of help in community planning. Since 1936 State health departments and State crippled children's agencies, in an effort to improve the health of children, have been drawing up annual plans of operation to qualify for Federal funds under the maternal and child-health and crippled children's programs provided for under title V of the Social Security Act. In all these, planning for hospital or convalescent home care figures largely.

The purpose of these programs is to improve, develop, and extend health and medical services to children. The State agencies determine the need for funds and submit plans to the Children's Bureau for furnishing services to children.

Next let us name certain underlying principles or conditions which should govern community planning for the hospital care of children, principles that have impressed themselves on us as these Federal-State cooperative services for children have developed. First, the most obvious: Health and medical services, to be of the greatest use to the individual child, must be accessible to him and they must be complete. Surely there should be a doctor within reason-

David is being cared for in the pediatric unit of a hospital. In this unit each bed is in a cubicle with windows, through which the nurse can see the children and they can see one another.

able reach of every child, and a hospital for the child's care as necessary—one that his parents can reach readily by the usual method of transportation. Where specialized pediatric and other medical service cannot be provided in his local community, there should be a plan for taking him to the place where it is available, or perhaps bringing it to him in special clinics or by a special consultant service.

Preventive, diagnostic, treatment, and after-care services should be integrated into a unified plan to meet the needs of the individual child. The chain of medical and hospital care provided in both smaller and larger communities should make available all the services essential for the adequate treatment of each condition, no matter how difficult of diagnosis or treatment. This requires the services of general physicians and specialists, nurses, nutritionists, medical-social workers, and workers in allied professions. In addition, recreational and educational services, child-welfare services, and any other services necessary to restore a child to full health must be available. The hospital will, of course, work with many other agencies, public and voluntary, in trying to reach this objective.

Secondly, experience has shown that in general the most economical method of providing hospital care for children is in special pediatric units within general hospitals of 50 or more beds. In small general hospitals with fewer than 50 beds, special arrangements for separate care of children should be made possible on a flexible basis.

Special children's hospitals as a rule are virtually general hospitals, self-sufficient in staff and equipment. They have played and still play an important role in establishing standards of care and integrating a diversity of services that are necessary for a well-rounded service to children. It is likely, however, that fewer such hospitals will be built in the future, as most communities find it too expensive to provide, in a special hospital of this type, the whole gamut of services necessary to treat the many conditions that affect children. When large communities can afford to build and maintain general hospitals for children only, there would seem no reason why this should not be done, particularly where the medical staff and all other persons involved in giving services can be integrated with the staff and the teaching program of a medical-school center.

In the same hospital, a nurse well trained in pediatrics is bathing Jeanne. Such a nurse plans her care of children in a way that will encourage each child's individual development.

Next I should like to point out that extension of hospital facilities for children in urban areas where already several hospitals exist will require careful planning in relation to the needs of each community and the special conditions that must be provided for. Providing hospital care for children is not just a matter of beds. Any extension of facilities needs to be planned where the services of physicians and others qualified to treat children are, or can be made, available. Early attention should be given to strengthening pediatric units now existing in communities where there are physicians with special training for the care of children. Other units, however, should be developed as need for them is shown, taking into consideration the population to be served, the accessibility of the proposed unit to the homes of the children and to other similar pediatric services, and the availability of professional services that will insure a high quality of care.

My fourth point also is obvious. Care for the ambulatory child patient and the convalescent child should be of as much concern to hospitals and the community as is the care of children requiring bed care in a hospital for acutely sick children. Communities and hospitals must concern themselves with providing facilities for ambulatory care in clinics and the services of skilled physicians and specialists to furnish the care and to offer consultation services to physicians in general practice.

For long-time care

More adequate provision for convalescent facilities for children who do not require the many services of a general hospital is another aspect to which more thought and planning must be given. We now know something of the numbers of children with chronic conditions who need care and we know that many are not receiving the care they need. But if we had data on the number of children now in hospitals whose condition would permit being cared for in convalescent facilities, better use of the beds now available in general hospitals could be made. Many of these children would be benefited physically or from a psychological viewpoint by being moved from the hospital to a good convalescent facility that is well-equipped and well-staffed to meet the requirements of children under long-time care. Such care in a convalescent home would have the

Given at the annual meeting of the American Hospital Association, St. Louis, September 23, 1947.

An orthopedic surgeon, internes and nurses join their efforts to give this child the best of care. And they are backed by other workers, such as medical social workers and nutritionists.

added advantage of being more economical to furnish.

These facts are well known to State health agencies and other agencies that administer services to crippled children. Any planning for the care of this group of children should be undertaken in cooperation with these agencies. Furthermore, guides in convalescent care have been worked out by a committee of the National Society for Crippled Children and Adults, in which the Children's Bureau has participated. Architectural plans for children's convalescent homes developed by this committee in cooperation with the architectural services of the U. S. Public Health Service are now available.

A convalescent home should preferably be developed in connection with a general hospital, both functionally and under its administration, to assure adequate direction of medical, nursing, and other professional services of high quality. It is desirable to have the convalescent home removed from the environment of the general hospital but not so far away as to be inaccessible to the general hospital. It is thought that a convalescent facility should not be smaller than 50 beds or larger than 100 beds—large enough to be economically operated, and so operated that the atmosphere of a home will be retained.

Community planning for any kind of hospital or convalescent care for children should obviously take into account standards that have been established for their care. The Children's Bureau has brought together available information and has set forth in its publications standards for various types of care in hospitals, including maternity care, care for the newborn infant, and also for the premature infant. The Bureau is interested in methods of maintaining pediatric-nursing standards. A study of pediatric nursing is now under way to develop a basis for determining these standards.

With respect to standards for medical care of children in hospitals or convalescent facilities, we believe that every child, whether a medical or a surgical patient, should come under the care or supervision of a physician who has had special training and experience in the medical care of children. When this is impossible, pediatric consultation service should be a part of the child's medical care by the hospital. This presupposes that a qualified pediatrician would be on the hospital visiting or consulting staff and always accessible for consultation to the private or other staff physician caring for a child.

For rural children

It is evident that to attain this standard it will be necessary to have pediatric services available to small communities and rural areas. This will mean developing an interrelationship between hospitals in the large centers and those in outlying communities. Such a relationship will make practicable a flow of professional consultation from the larger medical centers to the small community and rural hospitals and to itinerant or rural health clinics.

We know how to give good care to children, but we have not devised the ways and means to make it accessible and available to all families. Hospitals and health centers have been lacking. Economic and geographic barriers stand in the way. Tradition, too, has established barriers that figure largely in discussions among the professions and among the people. On both sides some traditional practices, though certainly not all, must be replaced with new ones. For instance, if care of high quality is to be made available there will have to be great extension and improvement of practice in groups whether in a hospital and clinic setting comparable to that in many hospitals today or in the setting of a privately organized group of physicians who are banded together to improve the care of their patients. Both these methods of group practice are well known today, but do not exist everywhere. Any group practice should include not only general family doctors, but also the specialists needed by the average family at frequent intervals, such as the pediatrician, and they should have access to complete clinical facilities, including hospitals.

The family doctor in our smallest towns and villages should also belong to such a group, even though the specialists of the group and the hospital and the diagnostic clinics are located in a centrally situated town and the general practitioners are located on the periphery. Under such arrangement the group practice must exist in fact and not in name only if the children in rural areas are to be served adequately. There must be a two-way exchange of consultation and service between a rural or small-town family physician and the central headquarters staff of the hospital and clinic. The community child-health service and the local health centers should be connecting links in the chain that binds rural physicians to the central group.

To make such a plan of small city and rural group practice work, hospitals and clinics, health centers, and child-health clinics must be constructed and equipped in many areas. The Hospital Construction Act now provides the means for making such a plan possible.

To bring services of high quality to

the small communities and rural areas, it is easy to visualize a chain of hospitals and clinics and health centers in every State, developed in accordance with its own particular circumstances. The chain of hospitals would reach from the large medical center to the large-community hospital, and on to the rural hospital and health center. Diagnostic and consultation services, and treatment that could not be provided in the rural or small-community hospital, would be obtained at the larger medical center. There could be itinerant diagnostic and health services to reach out into communities too sparsely populated to warrant permanently established clinics. These could also be connected with the chain of health centers, hospitals, and clinics, reaching back to medical centers. In my opinion the links in this chain will have to be forged together by the State and local health agencies who carry the public responsibility for seeing that the health interests of all the people of the State are served.

It is clear that in any planning for care of children in hospitals, the medical-school hospital is an important center to which outside communities must be able to turn. The teaching medical center must collaborate with State health agencies in taking responsibilities for promoting, developing, and improving health and medical services as far out as there is need for its services. The medical-school center is facing the day when it must join in taking such leadership by extending its knowledge, its skills, and its opportunity to stimulate higher standards in the fields of public health, medical care, nursing, and all the allied professional services involved in safeguarding and restoring the health of children and adults.

Comprehensive project reported

The program that has been developed for the care of children in the Upper Peninsula of Michigan is an example of the coordination of services that other communities could well study. A report of this was given by Dr. Moses Cooperstock in *The Modern Hospital* for May 1946. The report brings out how the department of postgraduate medicine stimulated a cooperative endeavor that promotes educational aims and opportunities for training, offers the medical services of a pediatrician of faculty rank from the medical school to the children in the Upper Peninsula, and makes diagnostic and treatment services available.

This Child Health Project at Rochester, Minn., demonstrates how services to the children of a community were assumed as part of the responsibility of a large teaching clinic. This is an integration of the efforts of local health and school officials, with the financial support in this case of the Mayo Foundation, the cooperation of the University of Minnesota's Medical School, the School of Public Health, and the Child Welfare Institute. This project is set up as a unit of the section on pediatrics at the Mayo Clinic. Here is a community health program that takes into account not only a child's physical health and welfare but his basic emotional needs as well.

At the heart of the planning for any program of care for children is the training of physicians and other workers in pediatric care, including training in the mental-hygiene aspects essential to good pediatric practice.

Adequate training in pediatrics for all nurses includes consideration of growth and development as well as the study of clinical conditions in children. Nurses preparing for positions in public work should be given additional opportunity to practice, under qualified supervision, the application of the principles of child care in a variety of situations, including those usually met in a broad program of community service. Consultants, instructors, and supervisors responsible for development of educational or service programs should have demonstrated professional competence in the care of children as well as having completed an advanced program of study in pediatric nursing.

In planning community health services for children, it has already been pointed out that the consulting services of pediatricians should be available for areas where there are no physicians especially trained in child care. Consultation services to hospitals by other types of consultants, nurses especially trained in pediatrics, nutritionists, and medical-social workers with basic knowledge of the health and social needs of children, are being developed by an increasing number of health departments.

Already, in 26 States, health departments have created positions for hospital consulting nurses on their staffs to improve maternity care and care of newborn infants. This pattern could be extended into the field of pediatrics with far-reaching benefits to children.

At present only a small proportion of hospitals have trained medical-social workers on their staffs. As with other professional personnel, there are not now enough of these trained workers to provide the services needed. Careful planning is required for the most effective utilization of those we now have and at the same time for the training of

(*Continued on page 126*)

These children are having fun while receiving long-time care in a convalescent facility. If such facilities are well equipped and well staffed to meet children's needs, better use may be made of the beds in general hospitals and—more important—many children will benefit.

PSYCHIATRIC TEAM HELPS DISTURBED CHILD

HENRY H. WORK, M. D. *Director of Mental Health Unit, U. S. Children's Bureau*

THOSE who work in fields that serve mothers and children, whether concerned with medical or social problems, are constantly aware that many things interfere with the smooth functioning of what should be a normal relationship. As a result problems arise which may alter the child's entire life and certainly affect seriously his personality development.

The past 40 years have seen a marked increase here in the United States, both in recognition of the child's difficulties and in means of coping with them. The growth of services to diagnose and treat personality disorders has taken many different routes; they include psychological services, habit clinics, child-guidance clinics, formal psychiatric services for children, and, finally a spread of psychiatric knowledge to the field of pediatrics, with extension to services concerned with prevention.

Began with backward children

The child-guidance clinic, regardless of nomenclature, has its roots in the many attempts to classify the functioning ability of feeble-minded children, largely on the basis of the possibilities of educating them.

A more recognizable origin for the present-day clinics is Dr. William Healy's work in Chicago in 1909. At that time, when Healy began to work with boys referred to him by the juvenile court, he introduced more dynamic concepts of the problems presented by the behavior of the children. His work set an example for the thorough study of the total make-up of these boys and gave a new conception of the workings of the individual. Healy was far in advance of his time, and there was little in the way of supporting services to aid him.

Ten years later there were only 7 clinics in the country for psychiatric work with children, but so great was the impetus of these that by 1939 there were 776 such clinics.

Along with this numerical growth there have been changes in the organization of clinics and a shaping of the personnel groups to fit the needs of the community that the clinics serve. These changes have been evolutionary, but at present the clinics are mostly centered around the pattern of what is known as the mental-hygiene clinic team, consisting of the psychiatrist, the psychologist, and the psychiatric social worker.

Psychiatrist directs clinic

The basic member of this team is the psychiatrist himself. Although there have been many clinics where members of other disciplines have played the greater part in organization or function, it is now well-accepted that the psychiatrist holds the responsibility for the plan of treatment of the children and for the diagnosis, based on his fully adequate knowledge of disease and disease processes. He alone has the medical background to see the complete individual and to evaluate the complex interaction of related disease conditions.

In most present-day clinics the psychiatrist acts as the medical or clinic director and supervises other members of the staff in their therapeutic procedures. On him also falls the job of teaching, especially the teaching of other physicians, a service that has always been an essential part of the clinic program.

Complementing his activities are those of the two other branches of the field which make up the team, the psychologists and the psychiatric social workers. Although child guidance began in the psychological study of the feeble-minded, later the practices of the psychologists proved to be of utmost importance in understanding the problems of the child in relation to his abilities. Introduction of the Binet-Simon test in 1908 spurred the activities of this group, and over the years their professional standing has increased and has lent a wholesome and critical adjunct to the psychiatrist in solving the problems of his patients.

At the present time, with a battery of testing material at their service and with a more thorough clinical knowledge of personality types, they are able to contribute enormously to the study of the disturbed child.

The third member of the team represents the newest of the disciplines, but the group of psychiatric social workers has grown to be both numerically important and of real worth in rounding out the combined functions of the clinic team.

Very early in the history of medical social work a few of these workers began to concentrate their efforts upon mental patients cared for in hospitals and clinics. As mental hospitals progressed, changing from custodial institutions to hospitals for the study, treatment and prevention of mental disease, the demand for social work for the patients expanded. However, the main development of psychiatric social services has been in the various psychiatric, mental-hygiene, and child-guidance clinics established to study and treat emotional problems.

Today psychiatric social workers represent an important element in every clinic, being responsible for most of the intake work, frequently handling therapy under the supervision of the clinic director, and maintaining an effective liaison between the clinic and the various independent organizations which the clinic serves. In terms of numbers they usually comprise the largest group of workers in the clinic, and their functions are adaptable to the variety of problems presented for care.

Teamwork pays dividends

The services which this clinic team has been called upon to perform have been as diverse as the capacities of the personnel and have reflected the variety of origins of its growth. Many of the clinics have not only been set up to meet the needs of a particular demand but have devoted much of their time to the solution of a special mental problem presented to them by a health or welfare agency. In the main, referrals have come from three sources: Health services, social services, and educational facilities, and while some clinics have devoted themselves to working for one of these sources, many of the clinics have served all three.

Written for presentation at the Ninth Pan-American Child Congress, Caracas, Venezuela, January 5–10, 1948.

In discussing the referrals that come primarily from the field of medicine itself it is curious to observe that guidance facilities often have had more difficulty in obtaining this type of referral than many others. In the present organization of clinics it is felt that the proper referral is from another physician, but often it was necessary for the clinic to prove its abilities before it could receive such referrals.

However, many physicians, especially pediatricians, now make wise use of the clinic's services. In many privately organized clinics the bulk of cases come from private physicians who recognize that the nervousness of a child is a symptom of a deep personality disorder and that the child needs the diagnosis and treatment which the clinic can provide. In public-health organizations both doctors and nurses were quick to see the advantage of these clinics for children whose symptoms were often those of organic disease but who presented no specific disease process and who later showed emotional difficulties. In this connection it should be mentioned that the clinics early demonstrated the marked correlation of emotional difficulties in the child with those in the parents and shaped their organizations so that they did not deal with the child alone but included the mother either in actual treatment or in a supporting role.

Organized health services gradually became aware of the possibility of using various members of the clinic team as consultants on their less serious problems; and in many areas where there was a dearth of personnel the clinic team functioned almost wholly in a consultative capacity, advising the medical and nursing personnel on specific cases. The psychiatric team has also been of great service in educating the members of the medical profession in a better approach to the child; in particular in their relation to him in the clinic, but in general in all their relations with children.

At all times in the history of development of social services for children there has been a keen understanding of the benefits of the psychiatric approach in case work and in the ordinary dealing with clients. No group has been so aware as the social workers of the possibilities of the guidance clinics and so eager to use them. It has been noted that throughout its history the National Conference of Social Work has presented on its programs psychiatric and mental-hygiene material, and throughout the social-work field there has been active use of clinics and their personnel.

In this field the use of the consultant has been carried to the point of perfection, and in some of our States the only psychiatric service provided for children has been in the form of traveling clinics advising child-welfare workers in the handling of their cases.

In the larger cities many agencies have retained individual psychiatrists as consultants and have used the clinics for their more seriously disturbed cases. In this general area one must consider work with the juvenile delinquent. In many cities there has been an intimate tie with the probation officers and court social workers so that the management of these children has been placed on a clinical basis, and a considered and intelligent approach to the problems of the delinquent child has been obtained. As was mentioned earlier, Healy's first work was with delinquents, and there has been a continual use and sharpening of the psychiatric resources bearing on this problem. At present the trend in this field lies in preventive work, and here again the clinic has been able to give wise counsel.

For disturbed school children

The abilities of the clinic were early and consistently tested by children whose difficulties first manifested themselves in the school situation. The schools have always remained a steady source of referrals, and much specialized work has been done with children whose problems were directly related to scholastic hazards as well as those whose difficulties antedated their school careers but whose symptoms were overlooked by parents and brought to light by a more observant teacher. In many cities the school departments have brought the clinic team into the school system and have rendered extensive diagnostic and therapeutic service to emotionally disturbed children. The psychologist has been prominent in this role, and both the psychologist and the psychiatrist have been successful in handling children with special educational problems where the fields of medicine and education overlap. Again in the educational field there have been problems in educating the members of the teaching profession itself to make them aware of their responsibilities toward children and of the actual psychological components of the teaching process. This area still requires much study and work and is another strain on the all too meager resources of the clinics.

The most hopeful aspect of the field of psychiatry for children lies in the expansion possible under the National Mental Health Act, passed to stimulate research, training, and services in the field of mental hygiene. When the full purposes of this act have been realized the adequate fulfillment of the mental-hygiene program can be anticipated. At present two important aspects of this program, that of research and that of training new personnel, are operating.

Professional standards set

Training for the separate disciplines follows definite outlines. The National Advisory Mental Health Council has set minimum qualifications for these positions, as follows:

The physician must first be a graduate of an approved medical school and have completed a year of general internship. This is followed by 3 years of further hospital work in the field of psychiatry, with some training in child psychiatry and then 2 years of practical experience, preferably in a guidance clinic.

The psychologist's training includes both undergraduate and postgraduate work in the specialty leading to a master's degree, plus 2 years of experience in an actual clinic, 1 of these years being supervised study.

The requirements for a psychiatric social worker include approved postgraduate work in this specialty, plus 1 year of full-time experience in social case work in a health or welfare agency with acceptable standards. An alternate requirement is completion of a 2-year course in social case work plus 1 year of experience of the type just described, under the supervision of a qualified psychiatric social worker.

All this training heeds the important factor of working as a group to mold the three professions into a well-functioning and effective clinical team.

Reprints available in about 5 weeks.

TO SAFEGUARD CHILDREN PLACED OUTSIDE THEIR OWN STATE

I. EVELYN SMITH,

Consultant on Foster Care, Social Service Division, U. S. Children's Bureau

WHEN A CHILD is taken from one State to another to be placed in foster care, he faces greater hazards to his welfare than if he were placed in his own State. And the social agency in either State that is responsible for his welfare finds all the usual difficulties caused by taking a child out of his accustomed way of life, plus some additional complicated ones.

Sometimes the child's new home is a long way from the former one; and distance itself may add to the child's emotional disturbance. Distance may also make it more difficult for the welfare authorities in the child's home State to protect him.

Arrangements have to be made for supervision of the child in the new home, and matters often become complicated when several agencies—State and local—have to take part in the placement.

One of the most important difficulties is caused by a requirement in some States that a child cannot be supported at public expense unless he is a legal resident of the State. As a rule, a child has his legal residence in the State where his father lives, and a child born out of wedlock has legal residence in his mother's State.

Sometimes a child is deprived of proper care by requirements concerning residence. For example, Jimmy, aged 4½, is mentally defective and needs institutional care. But he cannot be placed in a public institution in his State because of a technicality concerning his legal residence.

Jimmy's mother was unmarried, and during her pregnancy she left her own State and stayed at a maternity home in a neighboring State. After Jimmy was born she requested the maternity home to place him for adoption. and returned to her home State.

The maternity home placed Jimmy with a couple in a third State. But soon Jimmy showed signs of mental defect and the couple decided not to go through with the adoption. The maternity home then placed him in a boarding home, where he still is, in a very unsatisfactory situation. The boarding mother is old, is unable to give the child satisfactory care, and does not wish to keep him. His mother pays his board with great difficulty.

When the public-welfare department learned of this situation, it tried to get court action to place Jimmy in a public institution, but could not, as the court considered him not a legal resident of the State, but of the State where his mother lives. His mother's State will not accept responsibility for Jimmy, as he has never been in that State, and the State of his birth also disclaims responsibility.

Besides the difficulties caused by restrictions concerning the child's legal residence, there are problems due to differences in the States with regard to material matters. Resources, financial or other, that were available in the child's home State may be very different in the new State. One State may have, for example, better opportunities for children to live in family homes.

An example of a child's life being changed for the worse by a necessary removal to a State of poorer child-welfare resources is the story of Mary.

Mary was born after her father and mother had separated. Her mother kept her for a year and then paid her board in a family who loved the child and where she was very well adjusted. She went to school with the other children in the family and the neighborhood and was happy.

Then, when she was 8 years old, her mother disappeared. The foster family could not afford to support Mary, and the welfare authorities took steps to provide for payment of her board from public funds. But they soon learned that Mary's father was living in another State, which was therefore the child's legal residence. Although Mary's father was unable to support her, she had to be removed to his State, and the only provision that the State could make for her was in a public institution.

With the idea of exchanging experiences on problems like these, and the even more complicated problems of international placement of children, child-welfare workers in a number of States have for some time been expressing a desire for a conference on placement across State lines. Accordingly, members of the child-welfare staffs of the Illinois and Missouri State welfare departments sponsored a Midwest Conference on Interstate and International Placement of Children, which met at Pere Marquette Park, Grafton, Ill., October 6–7, 1947. Child-welfare workers from 13 States attended—Arkansas, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio, Oklahoma, and Wisconsin. Representatives of the U. S. Children's Bureau also participated.

Recent laws stress child's welfare

As a background for the discussion a staff member of the U. S. Children's Bureau presented a summary of State laws relating to interstate placement of children. This showed that most of these laws were passed in the latter part of the nineteenth century and the early part of the twentieth, before adequate State welfare laws provided for the licensing and supervision of agencies placing children. The earlier laws did not take into consideration the idea of cooperation between State authorities, but stressed protection of the State from casual and undesirable placement of children by persons or agencies from another State. These laws were passed to keep the State from having to assume responsibility for support of children from other States. Recent laws, on the other hand, emphasize the child's welfare, and some States have revised their early laws so as to provide protection for the child.

The conference agreed that in order to safeguard the child, as well as the family in which he is to be placed, and the State, the agency that plans to refer a child to authorities in another State for placement should provide a state-

Every child needs to be with his parents, as these twins are. Many are not; and State departments of welfare are much concerned about these children's welfare and happiness.

ment of all the essential facts about the case. Such a statement would include the reasons for considering placement of the child in the State, and also information on the child's personality and his most urgent physical and emotional needs. Such information was felt to be essential to enable the responsible agency in the receiving State to study the proposed plans for his care.

When it comes to the actual placement, all possible safeguards should be set up by the two responsible agencies—one in the child's home State and one in the new State—before the child goes to the new home. There should be a clear understanding with respect to the legal guardianship of the child. The family in which he is placed should be told why continued supervision of the child is necessary, and what to expect in the way of visits from representatives of the supervising agency. The division of responsibility between the two agencies should be made clear. The agencies should come to an agreement upon reports to be made on the child's progress and adjustment. Also there should be determination of who will be responsible for the child's support in case he becomes dependent. The two agencies should be clear as to who shall decide when supervision is no longer needed and the procedure to be followed if it becomes necessary to return the child to his former State. If adoption is the ultimate plan there should be an understanding as to which State the court petition is to be filed in, and after how long a trial period.

While it was recognized that the laws of both States must be conformed with, some workers felt that many State laws lag behind present-day philosophy and accepted social practices. This sometimes makes good planning in specific cases difficult. Since existing laws may not be changed soon, liberalizing of existing practices through administrative procedures where possible was recommended.

Children brought from other countries

The conference reviewed international problems relating to the placement of children in the United States from other countries. Some of the points discussed were admission of European refugee children, adoption of foreign-born children, placement of Canadian children for adoption in this country, bringing to this country children born overseas whose fathers were American servicemen, and caring for repatriated children returned to the United States by the State Department, unaccompanied by parents or other guardians.

Throughout all the discussions at the conference it was emphasized that good standards of work for children should be upheld in all interstate placement and that the welfare of the child should be the paramount consideration.

There was agreement that social services should be given to children on the basis of their own particular needs rather than on the basis of residence, unless the law specifically limits eligibility for services to persons who are legal residents of the State. The conference emphasized that the aim of meeting the individual needs of children could be realized more fully if Federal legislation would provide for financial participation by the National Government through grants in aid to States for foster-family care.

The findings committee was asked by the conference to prepare a draft for an agreement between the State from which a child is removed and the State in which he is to be placed. This agreement should include a statement of basic principles and procedures for interstate placement. It should also include an outline of information concerning the child, to be sent by the referring agency, and of information concerning the family under consideration for receiving the child into their care.

Such an agreement might serve as a tentative draft for consideration by the individual States with respect to the desirability of such agreements on interstate placement and the authority of the State to enter into them.

The findings committee was also requested to explore the question of Federal legislation regulating interstate placement or the possible passage of a Federal law authorizing the individual States to enter into interstate compacts or agreements on a voluntary basis.

The Children's Bureau was requested to (1) summarize in written form information relating to international problems concerning the placement of children, and (2) assist in developing a plan for a statistical study of the scope of interstate placements.

A follow-up conference was recommended for the spring of 1948.

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"The diversity of social-welfare practices is as great as is the diversity of climatic and soil conditions in the fifty-odd States, Territories, and possessions which comprise the United States. This could not be otherwise because of the different periods of settlement and the variety of backgrounds and economic conditions in the different States."—Emma O. Lundberg: Unto the Least of These, p. 10. D. Appleton-Century Co., New York, 1947. By permission of the publisher.

IN THE NEWS

United States Committee for ICEF Formed

The United States Committee for the International Children's Emergency Fund held its first meeting at the White House, January 19, 1948. This committee is a voluntary association of citizens, formed to advise the United States representative to the Executive Board of the International Children's Emergency Fund with regard to information and suggestions from United States sources regarding the work of the Fund. The membership is broadly representative of a wide range of citizens' groups throughout the country and of geographic areas. The chairman is Mrs. Oswald Lord.

The committee will cooperate with the American Overseas Aid-United Nations Appeal for Children.

Twenty-six nations are represented on the Executive Board of the ICEF. The United States representative is Katharine F. Lenroot, Chief of the U. S. Children's Bureau.

For Relief of Overseas Children

Individual contributions amounting to at least 60 million dollars are asked from the people of the United States to help meet the most urgent 1948 needs of distressed children and adults overseas.

Similar drives are being carried out in a number of other countries by the United Nations Appeal for Children. In each of these countries a national organization will collect the funds. In the United States this is being done by a campaign organization representing 21 voluntary organizations that are already furnishing relief in war-torn countries, and the United Nations Appeal for Children, whose proceeds in the United States will go to the International Children's Emergency Fund.

AOA-UNAC is strictly a collection agency, and does not itself furnish any food or services. It was formed at the request of the Department of State, in answer to an increasing demand from community leaders all over the country for unification of the many requests for funds.

Thirty percent of the 60 million dollars will be used by the participating voluntary agencies for services to families, medical programs for displaced persons, and related services, many of which affect children as well as adults. Seventy percent will go toward special children's activities—21 million for the ICEF and 17 million for the children's programs of the voluntary agencies.

The national drive has already begun; local drives will begin at various times, according to the situation in the various parts of the country. Many will begin in April. Local committees are being formed to participate in the appeal, along lines compatible with local practice.

Contributions to AOA-UNAC are deductible for income-tax purposes by specific Treasury Department ruling dated October 14, 1947.

The headquarters of American Overseas Aid and United Nations Appeal for Children is 39 Broadway, New York 6, N. Y.

The agencies participating in American Overseas Aid-United Nations Appeal for Children are: International Children's Emergency Fund (United Nations), American Friends Service Committee, Church World Service—Special Projects Division, Unitarian Service Committee, War Relief Services—National Catholic Welfare Conference, YWCA World Emergency Fund, American Aid to France, American Hungarian Relief, American Relief to Austria, American Relief for Czechoslovakia, American Relief for Italy, American Relief for Poland, Greek War Relief Association, Philippine War Relief (of the U. S.) Inc., United Lithuanian Relief Fund, United Service to China, AFL Labor League for Human Rights—Foreign Relief Program, CIO Community Services Committee—Overseas Relief and Rehabilitation Fund, Freedom Fund—Cooperative League of the USA, International Rescue and Relief Committee, International Social Service, Tolstoy Foundation for Stateless Russians.

Canadians Redraft Model Vital-Statistics Act

Registrars of vital statistics and legislative councils from eight Provinces of Canada met with representatives of the Department of National Health and Welfare and the Canadian Welfare Council December 1–4, 1947, to discuss a draft of a model vital-statistics act, prepared by a committee composed of staff members of the Dominion Bureau of Statistics.

Use of the short-form certificate was urged at the conference; also that birth certificates involving adoption and legitimation be filed at the Provincial rather than the local level. Exchange of adoption data was advocated, not only between Provinces, but between countries, also confidential handling and other procedure intended to safeguard data concerning births, adoptions, and so forth. As for the controversial questions concerning birth registration of allegedly illegitimate children born to married women, there was strong feeling in the group that common-law principles should be upheld.

The model act will be redrafted in the light of the conference discussion and will be submitted to the Vital Statistics Council and the Commissioners on Uniformity of Legislation before transmission to the Provinces. Each Province will, of course, be free to change the model act to suit its own views.

(For discussion of the social aspects of birth registration in the United States see *The Child*, August 1946 and June 1947.)

SOURCE: Concerning Children. Child Welfare Division, Canadian Welfare Council, Ottawa. December 1947.

Nebraska Expands Health Education

Health education in Nebraska is starting on a 3-year expanded program. Sponsors are the State departments of public instruction, of assistance, and of child welfare, in cooperation with the universities and teachers colleges. At each of these centers will be a health educator and a nutrition specialist who will teach and supervise in the area adjacent to the centers. State consultant services will be available as these are needed in the development of the program.

Films Show State Rheumatic-Fever and Premature-Baby Programs

A motion picture on rheumatic fever and one on premature infants—both for the public—have recently been produced by Virginia's State Health Department in cooperation with the U. S. Children's Bureau. These two films have been financed through use of grants to States administered by the Bureau under the maternal and child-health provisions of the Social Security Act.

Although Virginia is the State responsible for these two pictures, they have been produced on behalf of all State health departments.

The film, "We See Them Through," pictures Rhode Island's State program for children with rheumatic fever. It shows a coordinated program that brings together medical, medical-social, nursing, and other skills to treat children during the acute stage of rheumatic fever and the long convalescence from this serious disease.

"Starting Line" is the title of the other picture. It shows how the Illinois State Health Department is providing specialized care for premature babies from birth until they can be cared for by their mothers. Eventually Illinois hopes to have a network of premature-baby centers throughout the State for the benefit of all babies needing the specialized services.

The Virginia State Health Department is planning a third film, to be made in cooperation with the U. S. Children's Bureau. This will be on services for crippled children.

Crippled Children in Uruguay Attend Special School

Special attention to children with cerebral palsy is given at the Franklin Delano Roosevelt School for Crippled Children, in Montevideo, Uruguay, the first school for crippled children in South America. Established in 1941 by the National Association for the Crippled Child in Uruguay, the school admits without charge all children whose parents cannot afford to pay. Such children receive not only schooling, but also medical and dental care and clothing.

European Children Visit Britain

Many British families opened their homes last summer to children from war-devastated countries in Europe under a plan that begun in the middle of the war. It is the program of the Reception Committee, Young People from Occupied Countries, an organization recognized by the British Government but not subsidized. Under its sponsorship 15,000 private families have given temporary homes to young foreigners since 1942 in an attempt to provide a few months of relief from the miserable conditions of their homes in countries that were occupied by the Nazis.

In selecting suitable homes for the children, the committee writes to the mayor of a given British town, asking whether the community would be interested in offering hospitality. If the reply is affirmative, the mayor sets up a committee (of which there are now 200) of local citizens whose duty it is to select those homes which are most suitable, and to be responsible for the children while they are in residence. The children are divided into groups of 10; an adult accompanies each group from its own country, and keeps her charges under benevolent supervision throughout their stay. In general, the children visit prosperous working people, the local committee doing what it can to see that a child is received at a home fairly similar to that from which he came.

The purpose of the project is to remove the children from scenes of hardship and distress, and to receive them as members of the family in homes where affectionate care, rest, and good nourishment will restore them physically and emotionally. Strictly rationed though Britain is, her fare is abundant by standards in the homes of many of these young war victims. A month in the quarantine camp and 2 months with a British family have, in the past few years, meant much to thousands of young Europeans. Nor have the benefits been one-sided. The hosts have become quickly attached to their guests, and firm friendships have sprung up during the visits.

Haiti Legislates to Protect Children Employed as Domestic Servants

A law aiming at the protection of children under 18 placed in families for domestic service was passed in Haiti in September 1947.

Under this law, any person who takes a child into his home for domestic service must obtain a permit from the Bureau of Labor and must be at least 21 years old, free from communicable disease, and of good moral character.

Lodging, suitable clothing, and wholesome food in sufficient quantities must be provided for the child, and he must be allowed to attend school at least part time. Semiannual physical examinations at a public-health clinic are also prescribed.

The law prohibits employment of children under 18 as messengers or street vendors or in other similar occupations during the hours when they are required to attend school, or in the afternoon on Sundays or legal holidays, or between 7 p. m. and 6 a. m.

Labor inspectors may visit any home where a worker under 18 years of age is in service, for the purpose of investigating his or her living conditions. If these conditions are found unsatisfactory, the Bureau of Labor may return the child to his family, or, with the consent of the parents, place him with another family or in an institution.

In localities where there is no branch of the Bureau of Labor, enforcement of the law is entrusted to municipal magistrates.

Penalties are prescribed for violation of the law.

SOURCE: Communication from American Embassy, Port-au-Prince, Haiti, November 11, 1947.

• QUOTE UNQUOTE

"When we had a war to win and conscripted our youth to fight it for us, nothing was too good for them. We gave them first priority on our food and clothing. We taxed ourselves heavily to buy them the best. We provided them with the best training, the finest medical care, and the most expert personal services we could muster.

"Now we have a peace to win, and in labor's opinion nothing is too good for the new generation of children that is going to have to make that peace hold. Our children need—and must have—the best preparation the Nation can devise. That 'best' can be something much better than anything the children of the United States have had before. What's more, it must be!

"Labor is done now with the national mockery that panders to youth in war and penny-pinches children in peace.

"The world over, to grow well, every child needs to belong to a family: (1) That can obtain all the goods that make for the healthy growth and development of a child; and (2) that lives in a community where schools, medical care, and public welfare and recreational services are good. A minority of America's children in the past have been lucky on one score. Only a handful have had the breaks on both.

"Labor's fight for children focuses on both fronts: On building up family incomes to the level where each family can get the goods its children need, and on building up national income so that all communities can have better and better public and private services for children."

"CIO's Program for Children." In Economic Outlook, Jan. 1946.

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In the January issue of *The Child* we failed to give the sources that Anna Kalet Smith drew on in preparing her article, "Norwegian Schools Offer Health Services to Children." They are as follows:

Sources: "Skolehygienen," by the chief medical officer, Oslo Schools, 1947; articles by Dr. T. Gythfeldt, chief dental officer in the schools of Oslo, published in Den Norske Nasjonalforening mot Tuberkulosen, 1945, and in Sosialt Arbeid, 1943; Social Håndbok for Norge, 1937; and memoranda, issued in 1947, by the municipal school authorities of Oslo.

Children in Hospitals

(Continued from page 119)

additional ones. Plans will have to be worked out in cooperation with local health departments, particularly in rural communities, by which medical-social workers are employed by the community to serve more than one hospital or convalescent facility. More and more State health departments have medical-social workers on their staffs to consult with and help hospitals in planning for medical-social services. This source of help to local hospitals and community groups should be available in every State.

Nearly all State health agencies employ one or more nutritionists. Many of these nutritionists have completed an approved dietetic internship in a hospital. Now that they are in a position to influence community action, they can do much to see that nutritional gains that the patient makes in the hospital are maintained after he returns home. They can also help the hospital dietary staff in teaching both staff and patients because they are familiar with resources and food habits in the patients' homes and in which some of the student nurses and medical internes will work after their training. A growing number of State health departments employ consultant dietitians whose principal activity is to consult with physicians and nurses in hospitals.

We know that public interest in problems concerning the health of children is increasing. There has been a movement in the States for organizing committees, commissions, or councils to assume responsibility for planning health and welfare activities to meet the needs of children.

Hospitals should make it their business to know about such committees and commissions in their State or community. They should be represented in such planning groups so that hospital and convalescent care will be correlated with health service and medical care, with welfare and education in over-all programs to improve conditions for children. Planning is still pioneering and there is need for experimentation in which hospitals ally themselves with all other forces in the community to assure that the needs of children are met.

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Employment Service

(Continued from page 115)

programs are obvious. The school guidance program benefits by the addition of highly specific current information and by the wider points of view expressed by participants who are not a part of the school system itself. The local office benefits by the fact that the student, after graduation or drop-out, comes to the local office already partially equipped with basic information necessary to his final selection of an occupational objective and prepared to explore with the employment counselor the specific opportunities currently available and the relative advantages of different courses of action. If he is considering an occupation for which extensive training or apprenticeship is required, he may already know the extent and kind of this training and will have tentatively explored his ability to enter such a course of training with reasonable likelihood of being able to complete it.

Another area for cooperative planning by school and employment service personnel relates to the particular problem of the individual who, wishing to continue school, must yet seek part-time work and employment during summer vacations. More rapid and effective service to this group may be achieved if the school makes available its physical facilities and can arrange for group registration conducted by employment-service interviewers or counselors, to be followed, if necessary by evenly scheduled appointments at the employment office.

I should like to say in closing that public employment service holds very high hope for the continued improvement in the program for assisting youth to meet their employment problems. You may be sure that the national office will spare no effort in assisting you to keep the program geared to the changing needs of youth. This program, however, can be made dynamic only by local planning based upon careful analysis of the youth being served, what they can offer in the labor market, what the labor market can offer them, and the services which other agencies are equipped to provide.

Reprints available in about 5 weeks

• FOR YOUR BOOKSHELF

OUR RURAL COMMUNITIES; a guidebook to published materials on rural problems, by Laverne Burchfield. Public Administration Service, Chicago. 1947. 201 pp. $2.50.

This book gives a summary, with references, of information needed by persons planning action on rural problems such as those relating to schools, the church, medical care and health services, welfare, housing, recreation, local government, community organization, and land use in the rural community.

Although it is packed so full as to be almost a catalog of essential information, the book is also a stimulus and guide to those who are investigating the resources of the rural community and of the Nation in behalf of the rural community. It is an outgrowth of a brief digest of similar material on current activities of agencies interested in country life, and of literature on post-war planning for rural life, which was prepared for the American Country Life Association conference in 1944.

Stella Scurlock

INSTITUTIONS FOR CHILD CARE AND TREATMENT, by Mary Lois Pyles. Child Welfare League of America, 130 East Twenty-second Street, New York 10, N. Y. 1947. 28 pp. 50 cents.

Miss Pyles has here written about institutional work with special reference to case work in relation to other components of the care and treatment of children. She deals with changing attitudes toward children's institutions, the nature of institutional care, some guiding principles of modern institutions, contributions of case work, problems of case work in institutional care, and coordinated child care and treatment.

"It is the group living and group care situation," says the author, "which defines both the limitations and opportunities of the institution. It should be a guiding factor in determining the children who come to institutions and it enters into all efforts to help them."

Since institutional living is not an end in itself for the care of children, Miss Pyles points out that the institution needs to work toward the return of its children to their own homes or to foster-family homes as soon as possible.

It is accepted that institutions are called into being by social problems and have the responsibility of helping clients reach satisfying personal and social adjustment. As a social agency an institution needs to make use of social-work knowledge and skill in carrying on its work.

The need of the child for case-work service is discussed in relation to his admission to the institution and to his stay there, and also in connection with his leaving. Some institutions may try to add case work as an appendage, without giving it any real place in the life of the institution, but the service cannot be fully effective when given in that way.

There is a continuing need for the case worker, the cottage parent, the teacher, and the recreation leader to consult with one another. Teamwork is essential, but just as essential is leadership for the team from the administrator, who needs to understand the contributions of all parts of the program.

I. Evelyn Smith

TEAMWORK IN COMMUNITY SERVICES, 1941–1946; a demonstration in Federal, State, and local cooperation, by Katherine Glover. Office of Community War Services, Federal Security Agency. Washington, 1946. 80 pp.

Among the activities described in this account of a wartime experiment is the Government program for the day care of children of working mothers, which was carried out so far as possible through existing Federal agencies. The Children's Bureau and the Office of Education cooperated with Community War Services in developing policies and procedures for this program. The War Manpower Commission, the Army, the Navy, the Maritime Commission, the Federal Public Housing Authority, and the Federal Works Agency also cooperated in providing this much-needed service for children. The story of this and other services is presented not merely as a historical record, says the report, but also as significant background for the continuing development of community services.

SCHOOL-AND-WORK PROGRAMS; a study of experience in 136 school systems, by Caroline E. Legg, Carl A. Jessen, and Maris M. Proffitt. Joint publication of the Federal Security Agency, Office of Education; and the U. S. Department of Labor, Division of Labor Standards. 1947. 59 pp. For sale by Superintendent of Documents, Government Printing Office, Washington 25, D. C. 20 cents.

Programs combining school attendance with paid employment under which high-school boys and girls are released from some school time to take part-time jobs, gained sudden popularity during the war as a means of meeting demands of employers for young workers and the desire of students to become wage earners as well as to help in the war effort.

This war-born condition created a new interest in school-and-work programs (1) for educators because the realities of employment were brought closer to the school and (2) for those concerned with the protection of young workers because of the necessity for safeguarding the interest of these young people while on the job. Two agencies representing these two groups, the U. S. Office of Education and the U. S. Children's Bureau, accordingly began this joint study of school-and-work programs in 1945. Later the Bureau's Industrial Division became the Child Labor and Youth Employment Branch of the Division of Labor Standards, U. S. Department of Labor, and as such completed the study with the Office of Education.

The report describes the operation of school-and-work programs in more than 100 cities and analyzes their strengths and weaknesses. On the basis of the findings suggestions are made for the use of school administrators who are considering establishment of such programs.

WHEN YOU ADOPT A CHILD. Federal Security Agency, Social Security Administration, U. S. Children's Bureau. Folder 13. Washington, Revised 1947. 24 pp. Single copies free.

This is a revision of the folder formerly entitled "Adoption." It offers answers to many of the questions raised by couples who are thinking of adopting a child.

KEEPING UP WITH TEEN-AGERS, by Evelyn Millis Duvall. Public Affairs Committee, Inc., 22 East Thirty-eighth Street, New York 16, N. Y. 1947. 31 pp. 10 cents.

Persons who work with adolescents or with the parents of adolescents will welcome this lively, sympathetic description and explanation of some of the challenges offered by the teen age. Harking back to "When You and I Were Young, Maggie," the author shows how the problems that parents get into a stew about are related to the changed conditions under which youth lives today. She makes a good case for greater realization by parents that they need adaptability and capacity for understanding. No one is at fault, she is careful to point out, for the confusion and conflict between the two generations. Recognition of this fact may be the first step in bringing parents and teen-agers closer together.

This brief, readable pamphlet will stimulate many parents to take some of the positive steps toward better mutual understanding that Mrs. Duvall suggests.

Marion L. Faegre

Occupational Index, Inc., New York University, Washington Square, New York 3, N. Y., continues to publish six-page leaflets, at 25 cents, giving information on earnings, qualifications, opportunities, advantages and disadvantages, of various types of work. Among the occupations treated in these leaflets are a number that may be of interest to persons who wish to work with children.

The titles of a few of these leaflets, published in 1947, are: Librarian, Medical Secretary, Practical Nursing, and Psychiatry.

CALENDAR

Feb. 22–29—American Brotherhood Week. Sponsored annually by the National Conference of Christians and Jews, 381 Fourth Avenue, New York 16, N. Y.

Feb. 26—National Committee for Parent Education. Atlantic City, N. J.

Feb. 26–27—Conference on educational and recreational programs for children with orthopedic conditions. Sponsored by National Foundation for Infantile Paralysis. Held in connection with seventy-fourth annual meeting of American Association of School Administrators. Atlantic City, N. J.

Mar. 1—Child Study Association of America. Annual conference. New York, N. Y.

Mar. 7–9—Ninth Annual Southern Safety Conference and Exposition. Birmingham, Ala. Executive offices, 2120 First Avenue North, Birmingham 3, Ala.

In Laura, on our February cover, we see the typical American child, healthy and happy. Let us think also of those other children, in war-devastated countries, who are cold and hungry. And let us give what we can toward making life easier for them. The photograph is by Philip Bonn.

Credits for other photographs:

Pages 114 and 115, by Talbott for Look magazine.

Page 117, by Ben Greenhaus for Nursing Information Bureau.

Page 118, by Baltimore Sun, for James Lawrence Kernan Hospital, Baltimore.

Page 119, by Philip Bonn for U. S. Children's Bureau.

Page 123, by Woodrow R. Wilson for Federal Works Agency.

We Meet Again With Our Latin-American Neighbors

I have recently returned from the Ninth Pan American Child Congress, which was held at Caracas, Venezuela, January 5–10. I feel that this meeting has set a new milestone on the road to Inter-American cooperation.

It was a great experience to sit down again with representatives from other American nations, all working toward a single goal, the good of children.

The country where we met, Venezuela, is an inspiration in itself. For Venezuela, held back for years by a dictatorship, has made great progress in the last decade in providing for her children—their health, their education, their general welfare.

To Venezuela goes much of the credit for the success of the Congress. The Venezuelan Organizing Committee, under the chairmanship of Dr. Gustavo H. Machado, President of the Venezuelan Child Council, made the arrangements and prepared the program, with the cooperation of the American International Institute for the Protection of Childhood.

The Venezuelan delegation contributed what was perhaps the most important paper presented to the Congress, a statement of principles for legislation concerning the protection and welfare of children, including a declaration of the rights of the child and the duties and rights of the state. This statement of principles, or "children's code," was studied and revised by a technical commission and recommended by the Congress to the American Republics for their consideration, with such modifications as are made necessary by the constitutional system and the social and cultural conditions of each country.

In another important statement, the Congress affirmed the right of children to good health. This declaration will be put into final form by the American International Institute for the Protection of Children, working with the Pan American Sanitary Bureau. It will then be known as the "Declaration of Caracas on Child Health."

The Congress also made recommendations regarding Nation-wide organization and financing of health and social services for mothers and children. Some of its other recommendations concerned nutrition, prevention of tuberculosis, and the care of neglected children.

The child of school age was the subject of broadly conceived recommendations, founded upon the concept that the school is concerned with the well-being of the child in all the aspects of his growth and development. The Congress considered rural, preschool, and progressive education, and also took account of the needs of the child for protection and recreation outside school hours.

In all its recommendations the Congress showed a broad understanding of the close relation between health and social services.

The Congress strongly urged all American Governments and peoples to support the International Children's Emergency Fund and the United Nations Appeal for Children. At the same time it asked the ICEF to take into consideration the needs of the children of the Western Hemisphere, for many of these live in poverty and suffer from undernutrition.

Noting that another important Inter-American meeting is soon to take place, namely, the Ninth International Conference of American States (at Bogota, Colombia, in March 1948), the Congress requested this Conference to give due recognition to the special needs of children and youth. In this connection the Congress also stressed the importance of effective cooperation among the American countries in studying and solving problems relating to the health, education, and social welfare of children.

One trend that was noticeable throughout the sessions was the increased recognition that the Congress gave to the leadership of the American International Institute for the Protection of Childhood. To a greater degree than any previous Congress the Ninth Pan American Child Congress assigned to the Institute important responsibilities to be carried out in the immediate future and later. The presence of the Institute's president, Dr. Roberto Berro, and of its secretary, Dr. Víctor Escardó y Anaya, contributed greatly to the success of the Congress.

Katharine F. Lenroot

Chief, U. S. Children's Bureau

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Katharine F. Lenroot, Chief

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the CHILD

NATIONAL COMMISSION PREPARES FOR MIDCENTURY WHITE HOUSE CONFERENCE

U. S. SU[illegible] DEPT OF DOCUMENTS
MAY 5 1948

EDITH ROCKWOOD,
Office of the Chief, U. S. Children's Bureau

THE NATIONAL COMMISSION ON CHILDREN AND YOUTH, at its meeting January 28–30, adopted its Program for Children and Youth 1948; proposed a program of preparation for a midcentury White House Conference on Children and Youth, to be held in 1950; and made recommendations on international programs for children.

Seventy-six members of the commission were in attendance, including leaders in national organizations and professional associations concerned with the welfare of children and youth and representative State and local officials responsible for programs for children. Among the new members of the commission who attended were seven young people. Six are high-school or college students and one an industrial worker. Representatives were present from Puerto Rico and the Virgin Islands. Several Federal agencies that administer programs affecting children and youth sent representatives who shared in the discussions.

The commission meeting, under the chairmanship of Leonard W. Mayo, president of the Child Welfare League of America, began with an address by Oscar R. Ewing, Federal Security Administrator. Mr. Ewing urged extension of research in problems of child health and development and called for more medical personnel, better trained and better distributed; and for more local health units throughout the country. (Excerpts from Mr. Ewing's remarks are given on p. 134.)

What's new for children

The discussions opened with a series of brief talks by commission members, noting new knowledge and new skills that are benefiting children and new and old problems with which we still must cope. These remarks are reported here in part:

At a time when the welfare of children was subject to other drastic forces, changing economic and social conditions have caused a complete readjustment in the lives of a large part of our population, said Boris Shishkin, American Federation of Labor. Some 5,000,000 people went from farms to industrial life in the cities during the war years, and many have not returned. Millions of people, especially young people, have been away from their own localities, many of them abroad, and they have learned about the outside world. This kind of exposure to new ways of living has always had a tremendous effect on people, Mr. Shishkin said. And it has given many families and individuals a new outlook on life.

Leona Baumgartner, M. D., City of New York Department of Health, told the commission of the large reductions that have taken place in maternal and infant mortality since 1940, but added that maternal deaths, stillbirths, and infant deaths taken together still rank third as a cause of death in this country.

As for developments in medicine that are of benefit to children, she cited the "wonder drugs"—penicillin and sulfa—and the "comfort drugs," such as those that help to relieve asthmatic and allergic conditions; also the new operation for congenital heart disease.

Dr. Baumgartner mentioned the fact that more babies are being born in hospitals, with a doctor in attendance, than ever before. Also, she said, there has been more emphasis on training for doctors, not only in the medical schools, where obstetrics and pediatrics are given greater importance today, but also for doctors long out of medical school, who take postgraduate courses.

We now understand better the tie between mother and baby in early infancy, reported Esther McGinnis, American Home Economics Association. In response to demands by mothers, hospi-

In its new "Program for Children and Youth, 1948," the National Commission for Children and Youth pledges itself to focus public attention on the need for strengthening family life.

tals are beginning to plan so that mothers can keep their newborn babies in the room with them, and nurse them.

Now we are more willing to let the new father handle the baby, Dr. McGinnis continued, and we put new emphasis on the family in the baby's early development. We have more faith in the baby's ability to make his own schedule for eating and sleeping.

John P. Hubbard, M. D., American Academy of Pediatrics, sketched the Nation-wide survey of child-health services made by the American Academy of Pediatrics with the help of the United States Children's Bureau and the United States Public Health Service.

This has not been a study conducted from a central office, Dr. Hubbard said. It has been conducted throughout the country by all physicians that have an interest in children. And we have not intended just to gather a lot of facts, he went on, but to get these facts as the first step toward improved health services for children. We realize, he continued, that health services cannot be given to children anywhere unless there are persons qualified to render that care; and therefore we are giving very active thought to the need for more well-trained physicians who can be ready to give child-health services.

Probably the greatest single development in child health since 1940, in the opinion of Susan P. Souther, M. D., Ohio State Department of Health, is the increasing awareness of the public as to what child-health needs are and how to meet them. Farm groups, parent-teacher associations, war veterans, and various service and welfare organizations have instituted child-welfare programs or increased them, Dr. Souther told the commission.

Second in importance, she went on to say, is the increase in funds for maternal and child health under the social-security program, and the funds appropriated for care of wives and infants of servicemen, for school lunches, and for hospital construction; also the increased grants for dental work.

As the third major development, Dr. Souther named the growth of better local health facilities, which are necessary if adequate child-health services are to be developed. As the result of educational programs by public and private agencies to tell communities about the value of having full-time health departments staffed with trained personnel, several States in the past few years have enacted laws making it possible for district health departments to be established, or for several sparsely settled counties to combine into an effective health unit.

We have, however, a long and arduous task still ahead, said Dr. Souther, before good child-health services are available to all children.

Pediatricians are increasingly concerned about the psychological elements in disease, said George S. Stevenson, M. D., National Committee for Mental Hygiene, but even more they are con-

NATIONAL ★ COMMISSION ★ ON ★ CHILDREN ★ AND ★ YOUTH

PROGRAM FOR CHILDREN AND YOUTH • 1948

THE NATIONAL COMMISSION ON CHILDREN AND YOUTH pledges itself this year to:

Assist national organizations, their State and local affiliates, and members, in their efforts to achieve greater security and more opportunities for children and youth;

Cooperate with State commissions and councils and State and local officials working for children and youth;

Encourage youth participation in planning and developing community services on which young people can make a contribution;

Emphasize the obligation to remove all disadvantages to children that exist because of race or creed;

Stimulate preparation for a midcentury White House Conference on Children and Youth;

Encourage support of activities in behalf of children around the world through the United Nations and other appropriate organizations;

Focus public attention on the need for strengthening family life and extending opportunities and services, both public and private, to the end that these may be available for all children in the United States wherever they may live—

1. Adequate family income.
2. Good housing at reasonable cost for families with children.
3. Health services and medical care.
4. Mental health and guidance services.
5. Educational opportunities.
6. Recreational services and facilities.
7. Educational and vocational counseling and placement services.
8. Social services.
9. Legal protection through measures such as those relating to parental responsibility, adoption, guardianship, children born out of wedlock, juvenile delinquency, school attendance, and child labor.

cerned with the fact that parents are human.

Leaders in pediatrics today accept a more comprehensive scope than that of 1940, Dr. Stevenson told the commission, and there are now well-developed centers where training in this more comprehensive pediatrics may be obtained. The National Mental Health Act, he said, has opened up new opportunities for research, for training of personnel, and for development of clinical service.

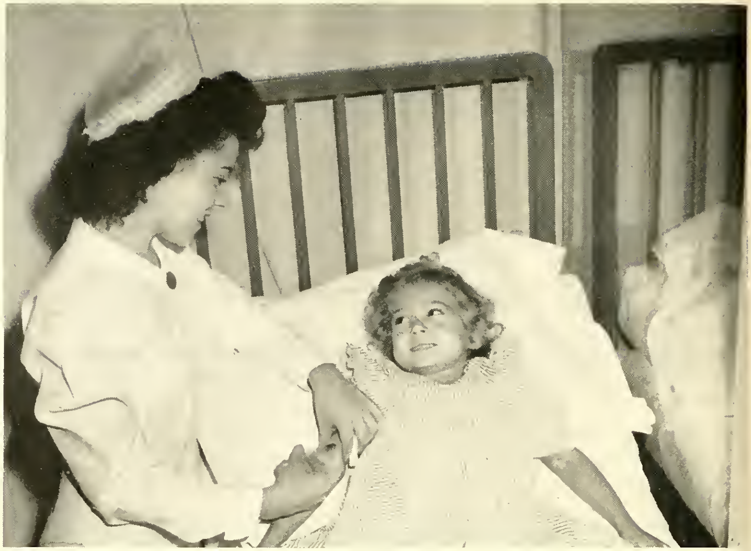
More and more the public-health nurse is becoming a family health adviser in the rearing of a healthy child, said Dr. Stevenson. In support of this the nurse is seeking more and better equipment; supervisors are being offered special courses; and mental-hygiene consultants are being trained. In the past, psychiatric education was almost completely ignored.

Education has made gains since 1940, in spite of teacher shortages and mounting school-construction costs, said Willard E. Givens, National Education Association. He listed some of the gains as follows:

School services outside school hours, on Saturdays, and during the summer have been developed; also additional learning experiences as part of the school program, such as camping. Human relations and social and economic problems now get school attention. The schools have come to recognize the importance of parent education in child growth and development, and also the educational importance of the preschool years. More attention is paid to the health needs of children, and their needs are considered more when school buildings are planned. Community resources are used more. Audio-visual aids to education have been developed. Continual attention has been given to functional teaching of the three R's.

Dr. Givens told the commission that the great increase in the number of babies born in the past 7 years is beginning to put pressure on school facilities, and that within a decade there will be 6,000,000 additional children of school age for whom no provision has been made, regarding teachers, school buildings, or equipment.

H. Councill Trenholm, State Teachers College, Montgomery, Ala., emphasized the differences in educational opportunity that exist in the various regions of the United States and among different groups of people.



Health services and medical care should be available for all children in the United States, wherever they may live, according to the National Commission on Children and Youth.

In the field of legal protection of working children, said Beatrice McConnell, U. S. Department of Labor, the period since 1940 has been one of slow and painful progress.

The chief gain, she said, is that 18 States now set 16 as the minimum age for full-time employment; this is 6 more States than in 1940.

To protect the young and immature worker by limiting his weekly hours of work is another important job, Miss McConnell went on. In 1940, she said, there were 11 States that limited the working week for children under 16 years to 44 hours or less. Since then 5 more States have been added to that number. In the same period 2 States have adopted a similar limit for children 16 and 17, making a total of only 6 who give this protection to these older children, who are still immature.

Since 1940, said Miss McConnell, two States have passed legislation to control to a considerable extent the employment of children in agricultural work. But the picture that we studied at the 1940 conference, of young children working long hours at arduous work, poor living conditions, poor housing, lack of health services, lack of community services of all kinds, lack of all the things that are important for children, is still before us in 1948. All this, she added, is particularly true of the children of migrant workers in industrialized agricultural areas.

W. S. Terry, Jr., American Public Welfare Association, noted that the States are increasingly recognizing the need for services accompanying monetary payments for aid to dependent children and are equipping themselves to render better services.

Mr. Terry also mentioned the increasing number of State commissions working on the problem of the needs of children and young people in their States. This, he said, is a hopeful sign, for it indicates a recognition of the problem of these needs and a seeking for the answers at the local level.

As we expand our concepts of child-welfare services and develop programs more extensively, said Ellen B. Winston, North Carolina State Board of Public Welfare, we realize that they must be grounded in sound bases of legislation. Again, she said, we may have good laws to protect children, but if they are to be effective they must be accompanied by expanded social services for children.

As we look at State activities in recent years, went on Dr. Winston, we see that we are concerned more and more with adequate legal protection for all children, not just for children who happen to fall into a specialized category, such as has been called a "delinquent child." Rather, she said, we are interested in getting legal protection for all children at all times.

Group discussions

Dr. Winston also presented to the commission a proposal to prepare for a midcentury White House Conference on Children and Youth, which was drafted by a committee to initiate plans for such a conference, under the chairmanship of Emma C. Puschner.

After this committee to initiate plans for the 1950 White House Conference submitted its proposal, the commission divided into groups for the discussion of two questions: (1) What should a 1950 White House Conference mean to children? and (2) what can we contribute to State and local action preparatory to the White House Conference? George B. Corwin served as coordinator for the group discussions. Joseph P. Anderson, H. L. Lackey, and John W. Edelman served as leaders for the groups and Margaret S. Harding, Margaret A. Hickey, and Mary E. Leeper served as recorders.

The conclusions of the group discussions confirmed the urgency of a midcentury White House Conference on Children and Youth and expressed approval of the "conference-in-process," which has already been begun in State and local efforts to achieve gains in advance of the 1950 conference.

Some of the suggestions were incorporated in the final proposal for the 1950 conference voted by the commission, and others will be used as guides for the continuing program of planning for the conference.

Among the suggestions made were that the planners (1) see the child as an integral part of the family; (2) see that security of family life is dependent on many factors, not the least of which is the basic economic security of the family; (3) see every American child in a dynamic national and world setting in which spiritual values, democratic practice, and the dignity and worth of each individual are basic; (4) think in terms of all children and not confine consideration to the most vulnerable ones; (5) see that young people have a realistic opportunity to share in all planning, in preconference projects, and in the conference itself; and (6) see that our concern for the child is no longer confined to the boundaries of our country.

The groups were in agreement in encouraging State and local groups to set goals for achievement in the next 2 years and in moving aggressively toward these goals. They called for concentrated effort for further establishment of inclusive State-wide organizations of citizen representatives from both public and private agencies concerned with the welfare of children and youth and for the strengthening of such bodies already in existence. They advocated steps to relate more closely the work of the several professions interested in the welfare of children. They proposed that national organizations share in the preparatory process by adopting 2-year goals and working actively toward their achievement through closer cooperation with their own State and local affiliates and with other organizations.

Proposal for a midcentury White House Conference on Children

In the light of the committee's report and the group discussion, the commission adopted the proposal for a 1950 White House Conference on Children and Youth.

The commission recommended that such a conference—the fifth decennial one—be held. This conference would be planned to evaluate progress since 1940, to assess the status of services and opportunities provided children and youth in the United States and the problems affecting their welfare, and to stimulate the Nation to achieve a greater measure of security and opportunity for all children. The commission also recommended that the conference place its primary emphasis on "The Child in His Family and Community."

The commission recognized that at the appropriate time a planning committee for a 1950 White House Conference on Children and Youth would need to be appointed to be responsible for organizing the conference. Pending the appointment of such a committee, the United States Children's Bureau and other Federal agencies responsible for programs for children and youth are in a position to cooperate with National and State organizations and agencies in the preliminary activities that will lead to a 1950 White House Conference.

The commission proposed two phases of preparation for a 1950 White House Conference: (1) A program of State and community preparatory action and (2) a preparatory research program.

Previous White House Conferences on Children have served as "starters" for State and local action on objectives agreed to by the National Commission.

This time the commission recommends a new and reverse approach: That the 1950 meeting come as a climax to a 2-year preparatory program of action in States and communities so that the 1950 conference can count gains made and plan for the next decade.

Attainment of goals or progress toward goals will require local initiative and action by voluntary and official agencies, and State leadership, financial aid, and legislation. Increased Federal aid in advisory service and funds will be needed to approach a comparable level of services for children and youth throughout all the States, Territories, and island possessions.

To consider how the program for preparatory action in States and communities can be started and carried on, a conference on State planning for children and youth is being called for March 30–April 1 in Washington, D. C., by the United States Children's Bureau, under the sponsorship of the National Commission for Children and Youth. Four or five persons are to come from each State to join in a working conference and report back to the groups in each State that will take the lead in planning the State programs.

For the research phase of preparation for the 1950 White House Conference the commission recommended appointment of a committee to consult with public and private agencies and to devise a plan for research preparatory to the 1950 conference. This plan will provide for analyzing data now available, assembling additional data needed, and evaluating information brought to light as it bears on the welfare and opportunity of children and youth in the United States.

(Continued on page 142)

FOR HEALTH, EDUCATION, AND WELFARE OF CHILDREN AND YOUTH

OSCAR R. EWING,
Federal Security Administrator

IN THIS COMMISSION, you have created a meeting place where you can pool your thinking about all facets of child life; the whole process of child growth and development; the total person and personality of the child. You have chosen to concern yourselves not only with a child's need for health services and medical care, but also for social services; not only with his educational, but also, his recreational needs; not only with child-labor laws and other legal protections, but also with opportunities for suitable employment and for growth in social responsibility. All this, not for any special group of children, such as the underprivileged, the Negro child, the child of migrant parents, but for all children of the U. S. A., even including the children of the far-away islands in the Pacific now under United States protection.

. . . . .

Modern science is helping us greatly in understanding the interrelatedness of human ills. The father who is sick in body may be sick from fear of unemployment or old age. The child who is failing in school may be failing because of neglect at home. The mother who is neurotic may be neurotic because of lack of economic help in holding her family together. Because of the breadth and inclusiveness of our programs, we are in an enviable position of approaching these very human problems from many different angles. . . .

When I speak of the breadth and inclusiveness of our programs, I am not unaware of their shortcomings. Our social-security system is only half finished. There are many millions who have no social-insurance protection. The protection against loss of income resulting from unemployment, old age, or death of the family breadwinner is far from adequate. The assistance we give to the States for the needy aged, for the blind, for dependent children is meager, indeed. Millions of children are deprived of their right to good education because we do not yet devote enough of our national income to provide the schools and the teachers needed.

We must push ahead on all these fronts. . . .

. . . . .

Extending medical research is one of the fronts on which I am convinced great progress can be made. At the present time, the Federal Government is helping to finance research to the amount of some $625,000,000 a year, but of that total only $28,000,000 or 4 percent is on health problems. The proportion of these $28,000,000 going to research on child health is almost infinitesimal.

I know how concerned the Children's Bureau is—and I imagine you share their concern—that so little is known about such problems as the cause and cure of rheumatic fever in children, and yet rheumatic fever kills more school-age children than any other disease.

Too long, we have been looking on congenital deformities in babies as acts of God. We know now that there is a large chance that the mother who has had German measles during the first 3 months of pregnancy may give birth to an abnormal child. We need to know a great deal more about diseases during pregnancy and their relation to congenital deformities.

There are a great many unanswered questions about the relation of nutrition to stillbirths and births of healthy babies; about the relation of the Rh factor to his chance of survival. We want to know how to prevent premature births.

We ought to be spending money, and to keep on spending it, until our researchers can tell us how we can avoid cerebral palsy. The ways in which physical and psychological factors interact on each other, both in the normal growth of children and in their illnesses and convalescence, need an immense amount of study. Accidents are a major public-health problem. More children die from them than from any single disease. Some children seem particularly prone to them. Why?

These are only a few problems of child health that we cannot master until we know a great deal more than we know now about child growth and development. You want more research on these problems. So do I. And so does the medical profession. I am going to do everything in my power to develop teamwork to make possible such research.

. . . . .

We need more, better trained, and better distributed medical personnel.

. . . . .

Doctors, citizens, and public officials, all of us want to build a solid foundation of local health units. One-third of our 3,000 counties still lack the services of a county health officer.

I give you these three examples—more research, more personnel, more local health units—as areas of need on which all of us are in substantial agreement. . . . I want to see how fast and how far we can move ahead in the protection of human life on these noncontroversial fronts.

. . . . .

Even in the short 2 years since your organization was formed, as a Nation we have made significant strides in the direction you want us to go. Federal grants to the States for child-health and child-welfare services have been almost doubled. We have made some headway in education. Teachers' salaries, on the average, are about $300 higher than a year ago.

I am glad your sights are high. It is going to take time to achieve your goals—how much time none of us can predict. But let me say for myself: I want you to count on my support in whatever you undertake to help communities and States create for their children and young people "full opportunity to develop their potentialities and to become responsible and cooperative members of society."

Excerpted from address given before a meeting of the National Commission on Children and Youth held in Washington, D. C., January 28, 1948.

STATE PROTECTS CHILDREN LIVING AWAY FROM THEIR OWN HOMES

VIRGINIA FENSKE,

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IN EVERY STATE many children are living away from their own homes and are cared for by persons other than members of their own families. In the United States as a whole about 225,000 children are so cared for—in children's institutions or foster-family homes. Besides these, large numbers of children are cared for during part of the day, in day nurseries, again by persons who are not near relatives of the children.

Since these children are not in the care of their own families, the State has the responsibility for seeing that they get the proper care. The State expects any agency or institution that undertakes to keep children to give them proper physical care, and to offer them adequate opportunities for mental, social, and emotional development.

During the past half-century nearly every State in the Union has passed laws designed to protect these children by requiring that no agency or institution may care for children without a license from the State. But in spite of this, many children live under bad conditions either because the law covers only children of certain ages, or children cared for by certain types of homes, or because the State agency responsible for administering the law is not adequately staffed to see that all the children are protected.

Characteristics of a good licensing law

What, then, is a good licensing law, without loopholes? What are the goals of good administration of the law? What methods of administration will lead to more satisfactory care of the children? And what achievements can be expected?

First, let us look at six characteristics of a good law:

1. The law should be definite in its provisions, so that the extent of its jurisdiction is understood; all terms should be clearly defined. At the same time the law should be flexible, so as to permit sound administration.

2. The law should be broad enough to protect all children coming under care of children's agencies and institutions and of independent foster homes, with no exceptions. Some State laws now exempt certain types of homes from licensing and supervision, such as those under sponsorship of religious or fraternal organizations or those caring for fewer than a specified number of children. Anyone taking part in drafting legislation to protect children should remember that one child in a foster home needs protection as much as several children do.

3. The law should provide that a State agency concerned with the welfare of children must pass upon not only the original incorporation of a children's agency or institution, but also all amendments to the incorporation. The law should require the State agency not only to examine the original bylaws but to give periodic examinations so as to note changes in them.

Through such provisions in the law the State agency knows at once when a new children's agency or institution is contemplated. If the new project is unsatisfactory the State agency has an opportunity to redirect or discourage it before it begins operation. In regard to existing agencies, such provisions permit the licensing agency to keep informed on any changes in the agency's plans.

For example, the law in the State of Washington requires a prospective child-caring agency, before it can be incorporated, to give the director of public welfare satisfactory assurance on the following:

(*a*) The good character and intentions of the applicant.

(*b*) The present and prospective need of the service intended by the proposed organization, with no unnecessary duplication of approved existing service.

(*c*) Provision for employment of trained and experienced workers.

(*d*) Sufficient financial backing to ensure effective work.

(*e*) Probability of permanence.

(*f*) Consideration of the best interests of the children and of society in the methods used and the disposition made of the children.

(*g*) Satisfactory provisions in proposed articles of incorporation and related bylaws.

(*h*) The need for and desirability of such an organization.

This requirement of the law gives the public welfare department in the State of Washington an opportunity to make a thorough evaluation of each new incorporated agency. Besides, we in the public welfare agency have found these points invaluable in explaining the law to new groups and in formulating rules and regulations.

4. The law should provide that the State administrative agency shall set standards for both new and existing agencies caring for children, and should place responsibility on the State agency for seeing that these standards are maintained. Supervisory activities by the State administrative agency might include visiting the agencies, examining records, and obtaining statistical and financial data.

5. The law should set a penalty for violation, with provision for initiation of litigation when an organization does not meet the State standards. The penalty clause should be stringent enough so that when prosecution is necessary it will be effective.

Condensed from paper given at the National Conference of Social Work, held April 13–19, 1947, at San Francisco.

6. The law should provide not only for rejection of a new application but also for discontinuance of any facility that does not meet State standards. In addition, it should provide that the applicant may request a hearing by the courts on decisions made by the licensing agency.

A licensing law with these six characteristics should make possible more adequate protection for children. It should also bring about coordination of public and private services for such protection and for a unified approach toward development of new services.

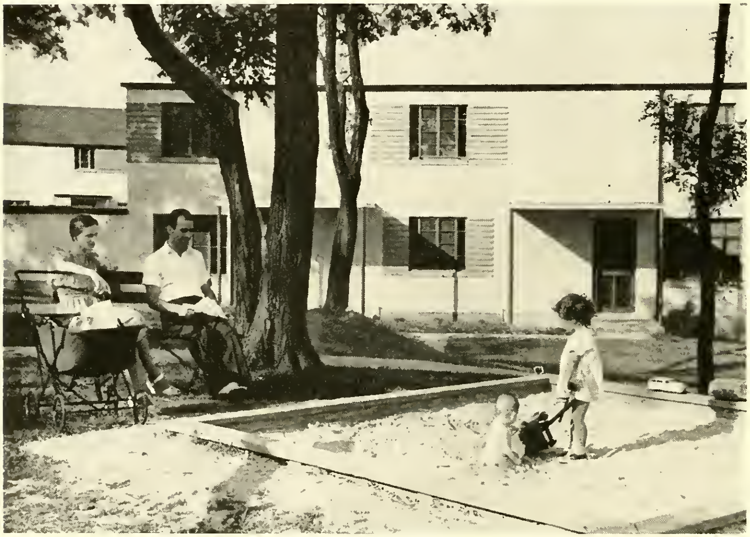
Given a sound legal base for administration of a licensing program, what does the public expect from it?

Dwight H. Ferguson in *Public Welfare*, October 1946, states "that one of the basic purposes of licensing is to insure against certain risks which we as individuals are not able to assume." He further states that "the purpose of licensing is to protect the child by identification of these risks and by establishing safeguards to meet them." This expresses what the public regards as our basic purposes in licensing.

The public is in a position similar to that of a patient who enters a hospital expecting that certain safeguards in regard to medical practice have been provided through national standard-setting agencies and through State regulation.

Likewise, a parent who enters his child in a day nursery wants to know that the child will have adequate physical protection as far as health, fire protection, sanitation, and nutrition are concerned, as well as a good program of child development and training.

It is generally agreed that administration of the licensing law should be the responsibility of the State agency concerned with the welfare of children. This arrangement facilitates coordination between public and voluntary programs for children. The licensing staff becomes familiar with children's needs and resources for meeting them, and can utilize this knowledge in planning a division of the field with private child-caring agencies. This staff can also be expected to give leadership so that private-agency services for children are utilized wisely. For example, unless the basic children's services are provided by the public agency, the private agency will be continually called upon to provide them. As a consequence, the voluntary agency will be retarded in developing new and specialized areas of service.



These children are happy in their own home. But 225,000 children in this country are in institutions or foster-family homes, and the States are responsible for seeing that these children receive proper care and adequate opportunities for mental, social, and emotional development.

The method of staffing the licensing program varies in the States, but usually one of two methods is used:

(1) Licensing personnel is employed on the State staff; the program is considered State-operated and functions entirely from the State level.

(2) Field representatives of the State agency are given responsibility for licensing of agencies and institutions in the area that they serve.

Of these two methods a State-operated program seems the more desirable, for a worker gains competence in licensing and supervision when this is a specialized job and is not carried as one element of a job involving responsibility in several areas. Also, the licensing staff is able to offer State-wide leadership because of their knowledge of needs, resources, and interagency relationships. This staff has responsibility for familiarizing other workers in the State agency with the licensing program and for interpreting to them the work of local child-placing agencies. This is an important part of the job, since the licensing staff has responsibility for helping local welfare departments to develop sound working relationships with child-caring agencies.

Assuming then that the licensing law is administered by the State public welfare department on a State-operated basis, what should be planned in regard to staff for the job? Unless the licensing program is adequately staffed, so that periodic studies can be made of agencies and institutions, licenses are issued without information concerning the current practices of the agency or institution. This gives a false security to the public, which assumes that approval implies knowledge of present conditions. "Adequately staffed" refers not only to the number of persons doing the job, but also to their qualifications. These qualifications should include professional training in social work; sufficient experience so that the worker knows voluntary and public welfare programs for children and can evaluate case-work practice; skill in teaching both professional and lay groups; and skill in consultation. Experience in an institution is of great value. Most of all, the worker needs sound judgment and ability to get along with people. The licensing job requires skilled personnel and should be compensated and classified in the merit system accordingly.

The staff is required to function in many areas. It works with boards and other groups; gives technical consultation in the areas of adoption, unmarried parenthood, day nurseries, foster care, and institutional operation; conducts surveys; directs a program of education and interpretation with professional staff and lay groups. Duties are numerous and often unpredictable.

With good legal structure and knowledge of basic objectives, what methods can be employed administratively to make the goals most effective?

The role of the licensing agency is twofold: (1) To carry out the provisions of the law; (2) to give consultation service to child-caring agencies and institutions so as to assist them in meeting the required standards.

When the home or institution does not meet the minimum requirements, the State agency, in carrying out its main function—to enforce the provisions of the law—may invoke court action to protect the children. This action will also set precedents for the required performance of agencies. The State agency also obtains attorney general's opinions for guidance. Through establishment of rules and regulations administrative procedures are developed.

Joint efforts to attain standards

The major approach to the licensing process should be educative, emphasizing supervision and consultation rather than authoritarian inspection. The State agency should attempt to develop a working relationship with agencies and institutions in the State, stimulating their interest in good methods of child care so that the process of licensing becomes a mutual effort to attain standards of care for all children.

The consultative relationship of the State licensing agency to the child-caring agencies will differ according to their need for such help and the mutual working relationship established. There will be agencies needing consultative service continuously or regularly and agencies having limited need for it.

The first group will be agencies located in a community where there is little professional leadership and no regular guidance from their national agency.

The second group will be agencies that have an adequate staff able to give leadership and that have consultative help available in the community through community councils of social agencies, schools of social work, or other media. Included in this group may be agencies with national private-agency affiliations from which consultation can be obtained.

The type of consultative help needed should be agreed upon through coordinated planning by the local supervising agency, the national private agency, and the State licensing agency.

For example, one private agency in the State of Washington which has national affiliation receives a visit from its national representative about once a year, other administration and supervision being carried on by correspondence. At the time of this visit the State consultant responsible for licensing confers with the national private-agency consultant and the local agency executive to consider mutual problems and objectives. Out of such conferences they reach agreements regarding consultation service to the local agency and division of responsibility for it.

Another part of the administrative agency's educational role has to do with standard setting. Since the applicability of standards will be best known to the agencies that must meet them, the setting of standards should be done by a joint committee representing the child-caring agencies and the State licensing agency. Such participation will promote sound working relationships and development of standards that are realistic in practice.

Agencies are in different levels of development, and standards should take this into account. Certain minimums, based principally upon the physical protection of children under care, should be required of all agencies.

For example, before being licensed, an institution would have to give assurance that standards for fire and health protection set by the State had been met; that there was sufficient staff, adequate financing, and a sound sponsorship.

In deciding upon standards, the licensing agency should not only take into account the State's development, but should incorporate into the standards objectives that agencies might be expected to reach and which some of them will already have attained. These standards, of course, will be higher than the minimum standards, which are intended to establish a base for appraisal of all institutions and agencies. In the event of legal testing, the minimum standards, which would be in line with generally accepted community practices, would be less likely to be considered inoperable or capricious.

To separate minimum requirements from objectives places emphasis on the objectives that the institution sees the need of attaining. It prepares the way for the agency to decide what objectives it can meet within a given time.

For example, a large congregate institution decided to make some building changes. They were faced with money limitations and an already existing plant that would have to continue to be used. Standards and objectives were reviewed with them, and they decided to follow a 3-year plan. The first year they would replace the laundry, which had been destroyed by fire; the second year they would modernize the dormitories, dividing them into smaller units, and the third year they would add a gymnasium. Since it was their own proposal and not something that the State imposed upon them, it had a better chance of being carried out.

Technical advisers needed

In standard setting and general administration of the law, cooperative relationships will be needed with other State departments, those concerned with fire protection, health, education, and building; the secretary of state; and the attorney general. These departments should participate in developing the rules and regulations. Their advisory help in regard to institution and agency operation will be invaluable in areas related to their technical skill.

Standards will need to be carefully drawn, since they become part of the legal basis for carrying out the provisions of the licensing law. If the requirements of the licensing agency are challenged, this legal basis may be needed.

The agency seeking a license—whether a new agency or one already operating—should be responsible for

(Continued on page 142)

FINLAND SAFEGUARDS HEALTH OF MOTHERS AND CHILDREN

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FINLAND'S geographical conditions place many obstacles in the way of our efforts to provide health services for mothers and children. It is located in the far north and it is extremely cold; it does not get the warming influence of the Gulf Stream nor the protection of mountains, as some other northern countries do. Its population is widely scattered over a large territory, including many islands. No wonder the infant mortality rate has been and still is greater than in some neighboring European countries.

Governmental and municipal child-health work was first started in Finland in the nineteenth century, but only for destitute children. This was all that was done by public authorities for many years. But for more than a quarter century private organizations have exerted much influence in the development of child-health activities. The most prominent of these is the Mannerheim League for Child Welfare, which is part of the Finnish Red Cross.

A general law for the protection of children, passed in 1936, and a law of 1944 concerning maternal and child-health centers, together with a public-health-nursing law of 1944, are the foundation for child-health work in Finland today.

The law concerning maternal and child-health centers requires every city and rural community to maintain at least one health center for maternity and child-health work. The Government pays the physician's fees and traveling expenses and three-fourths of the cost of equipment. The rest of the cost is paid by the local community.

The public-health-nursing law makes it compulsory for every local community to maintain a sufficient number of public-health nurses—in rural areas at least 1 public-health nurse to every 4,000 inhabitants.

The duties of a public-health nurse include care of infants and preschool children; also school health work; the tuberculosis service; control of contagious diseases, and bedside care at home in cases where it cannot otherwise be arranged.

Public-health nurses are engaged by the community. Three-quarters of their salaries are paid by the national Government and one-quarter by the local community.

Owing to the gradual improvement that has taken place in the standard of living and in child-health work the infant mortality rate in Finland has declined from 12.8 percent of the number of births, which was the rate during the first decade of the century, to 6.3 percent in 1945.

Among infants under 1 year of age the leading cause of death in 1944 in Finland was prematurity, which caused 26.4 percent of all the infant deaths. Second was pneumonia, which was responsible for 18.1 percent. Diarrhea ranked third, with 14.5 percent, and congenital malformations fourth, with 5 percent. In fifth, sixth, and seventh place were whooping cough, convulsions, and tuberculosis.

Diphtheria killed more Finnish preschool children in 1944 than any other cause; 20.1 percent of all the deaths among children of preschool age were due to this cause. Pneumonia was the second most important cause of death, with 14 percent. Third came tuberculosis (13.3 percent); and fourth, diarrhea (7.1 percent). Fifth and sixth were drowning and whooping cough.

Public-health nurses and special children's nurses have contributed greatly toward decreasing Finland's infant mortality. The training of these was begun in 1921, and skilled nursing staff was thus prepared for child-health work.

To reach isolated regions

Circulating child-health centers have also contributed much to the decrease in infant mortality. These were started during the war and still continue. The medical work of these centers is done by young doctors, who with public-health nurses visit remote parts of Lapland and northern Finland, both summer and winter, going to homes from which the nearest district health center is 25 to 60 miles away, a distance that could not be undertaken by the mothers with their infants. The doctors and nurses travel from village to village, and often from house to house, driving, walking or skiing, to give young mothers advice on the care of their children and to distribute foods and vitamins. (These traveling centers, or "neuvolas," were described in *The Child* for August 1947.)

In 1940 we saw how easily war increases infant mortality. Half a million people were forced to leave their homes at a moment's notice and move into temporary dwellings—often very poor ones—all over the country. This, of course, was injurious to the infants' health, and the infant mortality rose from 6.7 percent to 8.8 percent.

But the next year, in which the birth rate was far higher than it had been for a long time, the infant mortality decreased to 5.9 percent.

This good result was due chiefly to the sending out of more circulating health centers and to the exemption of children's doctors from military service. During the war medical care of civilians had to be given largely by children's doctors, as the other doctors were engaged in war work. The children's doctors therefore traveled all over the country, and as a result many children were given the help of a specialist who would not have had it ordinarily.

In addition to this temporary benefit, child health received a more lasting one in 1941 and 1942, when a number of children's hospitals were opened, through an organization called Finland Relief. As a result of these circumstances Finland's infant mortality in 1943, in spite of the war, was the lowest the country has ever had, 4.95 percent.

The following year about 400,000 Karelians and about 100,000 inhabitants of northern Finland were obliged to leave their homes, which had been destroyed. The temporary housing of these evacuees was better organized than it was in 1940, but it was still poor, and infant mortality increased to 6.8 percent. In 1945 it went down again to 6.3 percent.

Our infant mortality is higher than that in Sweden, Norway, or Denmark. This is due partly to geographic conditions, and partly to war evacuations, to poverty, to the housing shortage, and to poor nutrition.

The most important factor is, however, the large number of infants born prematurely. If we consider as premature any infant whose birth weight is under 2,500 grams (about 5½ lbs.), the number of premature births in Finland constitutes from 8 to 10 percent of all births. In Sweden only about 5 percent of births are premature.

Premature births must be reduced

The mortality rate among our premature infants is extremely high; about 50 percent die during the first year of life. Of all the infants who die during the first 7 days of life 70 to 80 percent are those who were prematurely born. This figure suggests that the most effective ways to decrease our infant mortality rate as a whole are (1) to reduce premature births and (2) to save the lives of premature infants.

Premature births are caused in many cases by illness during pregnancy—albuminuria, nephritis, eclampsia, and so forth, and these conditions can be prevented to some extent by intensive maternity care. Some premature births are caused by accidents due to work outside the home. These can be reduced through legislation for the protection of pregnant women who are employed.

Many more premature infants will be saved when the training of every midwife and public-health nurse includes care of such infants and when every children's hospital has a department for them, where they are taken care of with special attention and love. At this moment, the question of prematurity, not only in Finland but also in many other countries, is the most important point to be considered in our attempts to reduce infant mortality in general.

The rate of stillbirths is fairly constant and is almost the same in different countries. In Finland it varies from 2 to 2.5 percent of all births. Mortality during the first week of life is also comparatively constant at about 2 percent. The variations in infant mortality from year to year take place among infants during the later months of the first year of life. These variations are caused by many external factors, which can be influenced through child-health work.

We can be sure that our premature births will be fewer and the general infant mortality lower after our new laws on maternity care become effective, for maternal and child health are connected inseparably.

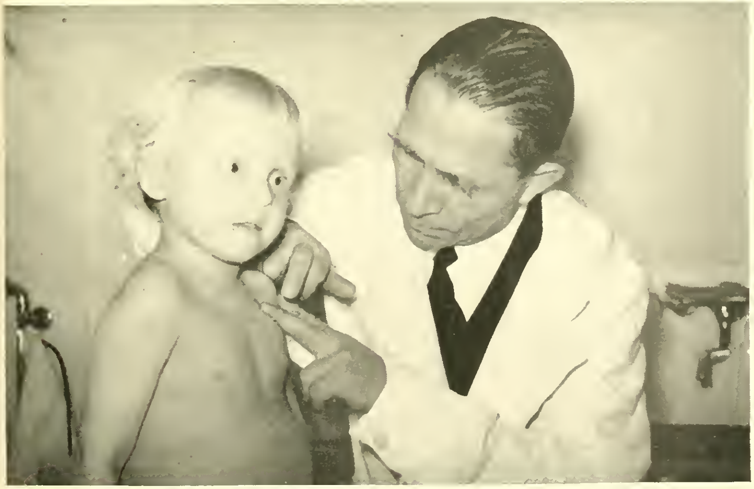
Our immediate tasks for the future in maternal and child-health work are:

1. To train skilled nursing staff—public-health nurses and special children's nurses—for different branches of child-health work. 2. To improve prenatal care, especially by preventing premature births. 3. To improve the care of newborn infants, especially those born prematurely. 4. To provide public-health education, particularly in the prevention of upper respiratory and intestinal infections. 5. To provide immunization against diphtheria, tuberculosis (Calmette vaccination), and whooping cough.

For these purposes we established, during the war, in spite of many difficulties, a new Children's Hospital, with 350 beds (picture on page 138). We are now building a new training center, called the Children's Castle, for all types of children's nurses. One hundred and twenty nursing students will train here each year. There will be 150 beds for children needing special care. These two new institutions will be a good foundation for every kind of children's health work in the future.

Reprints available in about 5 weeks

Dr. Arvo Ylppö, the author of this article, is shown here examining a young patient's chest.



TO TRAIN PERSONNEL FOR DELINQUENCY CONTROL

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CITIES, towns, and counties all over the United States are recognizing more and more the importance of the law-enforcement officer in the control of juvenile delinquency. Across the country, community after community is enacting legislation, providing funds, and encouraging and supporting administrators of law-enforcement agencies in setting up "juvenile bureaus" or "delinquency bureaus" within their agencies. These bureaus, by various names, are planned to permit the law-enforcement agency to specialize its work with young people and to refine its methods of dealing with them.

Specialization of work, of course, always raises the problem of special training for the workers. And as law-enforcement agencies move toward specialization of their work for control of juvenile delinquency, they find that their workers need special preparation.

There is, of course, no single answer to the question of what this special preparation for workers in juvenile bureaus should be. But the beginnings of an effort, in one State, to improve the work of these bureaus seem worth describing.

Law-enforcement administrators in California have long felt the need for improving their work for children and youth. And so, about 5 years ago, they joined with the University of Southern California in planning for a delinquency-control institute. This institute was planned not only to train workers in juvenile bureaus but to carry on research into problems of delinquency control, so that the curriculum would keep pace with knowledge in the field. The information collected through this research would be made available to law-enforcement agencies everywhere.

During the planning period, which lasted more than 2 years, specialists in sociology, in recreation, in education, in law, in social work, and in administration worked with law-enforcement officers in developing a broad course of study, including classroom instruction as well as practice and observation in local law-enforcement agencies.

The planners set a goal of training 60 juvenile workers a year. They did not, however, expect to reach this goal in the first few years of the institute.

The plan was to select not more than 30 workers in juvenile bureaus each half year for admission to the institute. These workers would be the ones recommended by their agencies for such training, and no requirement as to age or previous education would be set.

It was expected that the workers who attended the institute would be given educational leave with pay. The law permits local law-enforcement agencies to use public funds for this purpose, but not State agencies.

The university would give each person selected a scholarship to cover all tuition and fees for the institute.

A full-time course would be given, lasting 16 weeks. (The course has since been shortened to 12 weeks, as some agencies found it difficult to give up their workers for the longer time.)

As for the faculty of the institute, the planners agreed that the director of the institute should come from the law-enforcement field. The other two full-time members of the faculty would be a researchist and a supervisor of field work. One principle for selecting the three full-time members of the faculty was that the fields in which they had had experience should complement one another, so that their combined background would represent the total field of juvenile-delinquency control.

For administrative purposes the institute was placed in the school of public administration.

Funds for research were given, along with many other services, by the California Youth Authority. (Through research funds made available by the Authority, the planners were able to prepare teaching material. Scholarship funds were given by foundations.

The institute opened in September 1946, with 14 students. (It is now being given for the fourth time.) The director was the commanding officer of the delinquency-control unit of the Los Angeles Police Department, on loan to the university for a year.

This year the director is a lieutenant from the juvenile division of the Los Angeles County Sheriff's office, on loan on the same basis.

The supervisor of field work, both years, has been a person with social-work training and long experience in the field of probation.

The researchist during the first year was a person with experience in delinquency studies conducted by a Federal agency. This year the researchist is one who has recently been responsible for conducting community studies for the California Youth Authority.

The director is responsible for a course on "Administrative aspects of delinquency control." A member of the sociology department gives a course in "Conditioning factors in juvenile delinquency." "Social-treatment aspects of delinquency control" are taught by a member of the faculty of the graduate school of social work.

The school of education contributes the instructor in "Techniques of learning and teaching": this course was placed in the curriculum because the planners realized that many of the workers attending the institute would sooner or later become supervisors and would need to know more about what is involved in the teaching process.

"Delinquency-prevention techniques" are taught by a member of the university's psycho-educational clinic. A course in "Legal aspects of delinquency control" was developed by an instructor on the law-school faculty.

Students visit juvenile bureaus

One full day a week is devoted to supervised field work, and the students visit various departments or agencies within the Los Angeles metropolitan area. The largest number of agencies visited are juvenile bureaus, where the student has an opportunity to study departmental structure, policies, and practices. These bureaus, varying as they do in size and program, present variety and provide rich material for study. As a result of these visits the student may arrive at a better judgment as to what is best for his own community. Other agencies visited are the Los Angeles County Probation Department and the Juvenile Court. In addition, the Youth Authority arranges visits to several of its group-care facilities that are located within the area. After the field visits, opportunity is given at clinics in delinquency control for the students to discuss the visits fully.

The classroom-teaching method in the courses varies according to content and instructor, but the accent is on discussion, with frequent use of special study-and-report committees. One deviation from regular college methods is devotion of a much greater amount of time to class sessions. In fact the teaching policy might be said to be built on group teaching. Opportunity does exist, however, for individual study, preparation, and conferences.

For good public relations

Each person completing the course receives a certificate, and students with certain previous educational achievement receive 12 units of college credit. In the final week of the course a dinner meeting is held, at which the certificates are issued. Officials in the law-enforcement field, including chiefs of departments sending students to the institute, are invited. This affair has proved to be especially good public-relations work for the project.

Applications for entrance to the institute are reviewed by a joint committee of law-enforcement officials and faculty members of the university, which makes recommendations to the university-admissions office.

The total student enrollment of the first three semesters amounted to 30 men and 7 women. The age range has been from 26 to 52 years, with a median age of 35. The educational backgrounds have ranged from less than high-school graduation (in two instances) to college graduation (in eight instances), with the median achievement the completion of a full year of college work.

Sixteen different public agencies have been represented by one or more workers each. The locations of these agencies range from the "Bay region" of San Francisco to San Diego. (Several applications from outside the State are being considered for the coming quarter.) Twelve of the public agencies are municipal police departments; two, sheriff's offices; and two, probation departments. Within the law-enforcement-agency group of employees, the rank of those attending has ranged from new appointees with patrolman status to a lieutenant in charge of a juvenile bureau.

To evaluate the project was not the purpose of this statement. But it does seem appropriate to comment on some of the decisions on the planning, which experience seems to be validating. Perhaps the first and most important decision in the early planning was that this project was to be truly a joint undertaking of the university and the field of law enforcement. During the years of the planning phase, each aspect of the project was considered in detail by a joint committee, composed of staff members of the university and representatives from law-enforcement and other fields interested in juvenile-delinquency control.

During the planning period a 2-day law-enforcement officers' conference on juvenile-delinquency control was held on the campus of the university. This conference had the sponsorship of the attorney general of the State, the California Peace Officers' Association, the California State Sheriffs' Association, the District Attorneys' Association of California, the California Youth Committee, and the California Youth Authority. This conference adopted a resolution supporting the development of an institute. Since the conference, these law-enforcement groups have been kept informed of developments concerning the institute and have continued to manifest interest and give support. In fact, there is abundant evidence that the law-enforcement group feel this is their project.

Another decision which would seem to be sound, although further time is necessary for final validation, pertains to the combining of teaching and research.

During the first year the research side had to be somewhat curtailed and made very practical. The researchist devoted considerable time to preparing teaching material and revising the syllabi that had been prepared before the opening of the institute. There was enough time, however, to survey the research needs of the law-enforcement field in respect to juvenile work.

In the second year, an increasing emphasis has been placed on the research function of the institute. A joint research committee has been organized, including representatives from the field of law enforcement, staff members of the institute, and faculty members from other departments or schools of the university. Biweekly meetings on research are held, with a professor in the department of public administration serving as chairman or moderator, and the researchist as field secretary.

Research on practical problems

Although specific research projects are only in the blueprint state, one tangible result is at hand. The mere coming together of the law-enforcement workers and university instructors, in order to think about undertaking research, proved to be an excellent device for helping the institute to keep focused upon practical problems. At the same time this serves as a means of helping the practitioners to appreciate and see a little more clearly the difficulties involved in gathering real knowledge. It would seem that this increased awareness upon both sides must make for greater cooperative activity.

In this descriptive report there are two statements that should be made to correct any false impressions.

First, it has not been intended to convey the impression that serious problems have been lacking. Not everything has moved smoothly. There have been many perplexing problems, and the future will bring many more.

Secondly, it has not been intended to imply that the "institute" idea, as here described, is *the* answer to the training of staff members of juvenile bureaus. Many different approaches to such training have to be made and the best of each welded into a new "best" approach—best for the time being. What has been reported here is simply one approach, one way of doing. It may help to suggest other ways.

Reprints available in about 5 weeks

NATIONAL COMMISSION

(Continued from page 133)

In a progress report the commission noted advances that have been made in carrying out its action program for 1947 and 1948, the program adopted at its December 1946 meeting.

The commission adopted a program (presented on p. 131). It also authorized issuance of an explanatory statement, "Next Steps for Children and Youth," which sets forth for each phase of the commission's program the situation affecting the welfare and opportunities of children and youth and action needed to benefit them. After final revision in the light of suggestions made by commission members, this statement will be published by the United States Children's Bureau in combination with the commission's Program for Children and Youth, 1948.

Adopting a series of recommendations related to international programs for children, the commission advocated sufficient funds for financing the European recovery program, and urged consideration, under that program, of the needs of children, as well as of the necessity of providing services essential to the most effective use of material aid.

It called for support of the American-Overseas Aid-United Nations Appeal for Children and continuation and expansion of programs of voluntary agencies that are providing valuable assistance to children and youth in other countries. The commission is to keep in active touch with United States representatives in international agencies, public and private, to further programs for the children and youth of the world and to bring about a more coordinated approach to the needs of the whole child.

The recommendations urged prompt consideration of action needed to make it possible for larger numbers of displaced and unaccompanied children in Europe to come to the United States.

The commission endorsed the programs being pressed by United Nations Educational, Scientific, and Cultural Organization for educational reconstruction in war-devastated areas and for the promotion of opportunities for fundamental education for all children and youth and asked national organizations to participate in support of such programs.

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CHILDREN AWAY FROM HOMES

(Continued from page 137)

taking the steps required for licensing. For example, after the licensing agency notifies the commercial operator of a maternity home of its responsibility to obtain a license, it becomes the duty of the maternity home to apply for a license and conform to the rules and regulations of the State agency.

One point concerning which the State agency and the agency seeking a license should work together is in determining the numerical capacity of an institution. It is accepted practice to include the maximum capacity on a license. If this figure is worked out by the licensing agency and the applying agency together, and is calculated in relation to the total number of staff, intake policy, financing, and physical space and equipment, it will have more meaning.

In its educational role, in addition to consultation, the licensing agency will need not only to give consultation but to conduct group institutes on child-welfare subjects, to hold regular group meetings with the staffs of institutions and agencies, to participate in agency surveys, and to cooperate with national and local planning groups related to the local organizations so that common objectives can be coordinated.

We have considered the legal and administrative structure of a State licensing program for children's agencies and institutions. What are the positive gains we can expect from a program, which is legally sound and is adequately financed and is staffed so that it can be effectively carried out?

The first gain we can expect is State-wide maintenance of at least an acceptable standard of care for children, with progressive growth in the direction of better standards of care.

Secondly, we can expect further understanding between public and voluntary agencies as sound working relationships are developed and as planning for care of children is coordinated.

Thirdly, and last, we can expect future development of children's services to move in the direction of providing wider coverage so that adequate protection will be given to all children who need it.

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• IN THE NEWS

To Set 10-Year Health Goals for Nation

Oscar R. Ewing, Federal Security Administrator has called a National Health Assembly, to meet in Washington May 1–4. The Assembly has been called as a result of a letter dated January 30, to Mr. Ewing from President Truman, in which the President requested Mr. Ewing to undertake a comprehensive study of the possibilities for raising health levels in the United States. In this letter the President further asked for a report upon feasible health goals which might be realized by the American people in the next decade.

Thirty or more national leaders in various fields have been invited by Mr. Ewing to serve on the executive committee of the Assembly.

The Assembly itself will consist of both technical and lay personnel. Thus it will include not only representatives of public and private organizations in the United States concerned with various phases of the Nation's health but also of the people who are the consumers of health services.

According to preliminary estimates, more than 800 persons will attend the Assembly sessions.

Most of the activity of the Assembly will be in the form of panel discussions. Fourteen panels have been planned, each to explore a specific phase of the health problem.

The panels are on: (1) Professional personnel; (2) Hospital facilities; (3) Local health units; (4) Chronic disease; (5) Maternal and child health; (6) Rural health; (7) Research; (8) Medical care; (9) Community planning; (10) Rehabilitation; (11) Dental health; (12) Mental health; (13) Accidents; and (14) Nutrition.

Leona Baumgartner, M. D., is chairman of the panel on maternal and child health. This panel will stress the mother-child relationship with regard to the newborn infant, and also the health of the school-age child. Chairmen of the other panels will be announced later.

Mr. Ewing described the job of the Assembly as: (1) To see what we have—to know accurately the health facilities and personnel of the Nation and of each community—(2) to determine what we need (the difference between the two will show us our health deficits); and (3) to devise feasible methods of meeting these deficits.

As immediate benefits that should

come out of the Assembly, Mr. Ewing lists: (1) A guide to community action for local health improvements; (2) a detailed, practical pattern of cooperation among all organizations operating in the health field—public and private—National, State, and local; and (3) a more detailed and specific knowledge of our present health picture and of the job that has to be done to improve it.

Fellowships in Psychiatry Offered to Physicians

The American Association of Psychiatric Clinics for Children offers fellowships for training in child-guidance-clinic psychiatry under the auspices of the United States Public Health Service, The Commonwealth Fund, and some local funds. The training is for positions in community clinics, where psychiatrists, psychologists, social workers, and others collaborate in the treatment of children suffering from emotional or mental illness.

Most of the fellowships are for 2 years; some for 1. The stipend is $3,000 for the first year, and more for the second. Prerequisites are graduation from an approved medical school, a general internship, and 2 years of general psychiatry.

Opportunity is provided for the fellow to develop his own skills in a well-organized out-patient service, with the support of a carefully planned training program and adequate supervision. The training centers are selected on the basis of standards which have been established by the American Association of Psychiatric Clinics for Children, and the fellowships are awarded by a committee of this organization.

For further information write to Dr. A. Z. Barhash, Executive Assistant, The American Association of Psychiatric Clinics for Children, 1790 Broadway, New York 19, N. Y.

CALENDAR

Mar. 20–22—Sixth Annual Border Health Conference. United States-Mexico Border Public Health Association. Laredo, Tex., and Nuevo Laredo, Tamaulipas, Mexico.

Mar. 22–25—American Camping Association. Los Angeles, Calif.

Mar. 29–Apr. 1—National Vocational Guidance Association. Chicago, Ill.

Mar. 29–Apr. 1—Council of Guidance and Personnel Associations. Chicago, Ill.

From Mar. 30—Union of American Republics. Ninth international conference of American States. Bogota, Colombia.

Mar. 30–Apr. 1—Conference on State and Community Planning for Children and Youth. National Commission on Children and Youth. Washington, D. C.

Mar. 31—Alliance for Guidance of Rural Youth. A panel discussion on Planning for Youth in Rural Industrial Communities, in connection with the convention of the Council of Guidance and Personnel Associations. Chicago, Ill.

Apr. 4–11—National Negro Health Week. Thirty-fourth observance. For information: National Negro Health Week Committee, Federal Security Agency, Public Health Service, Washington 25, D. C.

Apr. 5–7—National Society for the Prevention of Blindness. Minneapolis, Minn.

Apr. 11–17—National Public Health Nursing Week. Fourth annual observance. Further information from the National Organization for Public Health Nursing, Inc., 1790 Broadway, New York 19, N. Y.

Apr. 12–14—American Orthopsychiatric Association. New York, N. Y.

Apr. 17–23—National Conference of Social Work. Seventy-fifth annual meeting. Atlantic City, N. J.

Apr. 17–23—International Conference of Social Work. Atlantic City, N. J. Further information from Joseph Anderson, Acting Secretary General, 130 East Twenty-second Street, New York 10, N. Y.

Apr. 19–23—American Association for Health, Physical Education, and Recreation. Kansas City, Mo.

Apr. 19–23—Association for Childhood Education. Fifty-sixth annual study conference. St. Louis, Mo.

Our March cover shows youngsters that have health and welfare services available to them. The National Commission on Children and Youth is working toward goals that will make such services available to all children in every part of our country. The photograph is by Esther Bubley for U. S. Children's Bureau.

Credits for other photographs: Page 130, Federal Security Agency. Page 132, by Ben Greenhaus for Nursing Information Bureau. Page 136, Federal Public Housing Authority. Page 138, by Samuel Krakow, American Red Cross. Page 139, courtesy of the author, Dr. Arvo Ylppö.

C. B. PUBLICATIONS

CHILDREN SERVED BY PUBLIC WELFARE AGENCIES AND INSTITUTIONS, 1945. Federal Security Agency, Social Security Administration, U. S. Children's Bureau. Statistical Series, No. 3. Washington, 1947. 18 pp. Single copies free.

This bulletin presents two separate but closely related aspects of services for children under public auspices: Children served in public child-welfare programs and children served by public institutions. "Children Served in Public Child-Welfare Program," is a summary and analysis of data that are reported annually to the U. S. Children's Bureau on the characteristics of children receiving child-welfare services from State and local public welfare agencies. "Children Served by Public Institutions," is the first summary and analysis of annual reports received by the Bureau on children served by State and local public institutions for dependent and neglected children or delinquent children. It includes both children living in the institutions and children served outside the institutions by institutional staffs.

LEGISLATION ON JUVENILE COURTS IN FOREIGN COUNTRIES, by Anna Kalet Smith. Federal Security Agency, Social Security Administration, U. S. Children's Bureau. Washington, 1947. Mimeographed. 70 pp. Single copies free.

This report aims to give information on the extent and nature of juvenile-court legislation outside the United States. For each country in which laws on juvenile courts and on procedures similar to those of juvenile courts are known to exist, the report makes brief mention of the history of this legislation and gives a summary of the present laws. The summaries have been prepared in almost all cases from the original text of the laws.

BREAST FEEDING. Federal Security Agency, Social Security Administration, U. S. Children's Bureau. Folder 8. Washington, Revised 1947. 21 pp. Single copies free.

Many mothers get a feeling of happiness and closeness to the baby when nursing him that they get in no other way, says this folder, which begins with plans for breast feeding made before the baby is born and ends with a plan for weaning.

For Every Child a Fair Chance

We now have the means at our disposal for a great advance toward achieving the goals for children and youth which the National Commission on Children and Youth has set forth in its program for 1948.

We know more of what makes good health—physical, mental, and emotional—and how the pattern begins to be formed in earliest infancy.

We have many more facts about the extent to which services provided in communities reach children; as, for example, the information gathered in the Nation-wide study carried on by the American Academy of Pediatrics with the help of Federal agencies. Encouraging gains have been made in many fields, as reported by commission members in the January meeting. And the public knows more about children, their needs, and programs developed in their behalf.

At the same time, members of the commission face the fact that the road ahead to opportunity for all children is long and arduous. To speed up travel along this road, and to find any short cuts that may exist, the commission has outlined a new kind of Midcentury White House Conference on Children—a conference-in-action—of which a meeting in Washington sometime in 1950 will be the climax but by no means the whole. For it is the hope of the commission that communities and States as well as many national organizations will endeavor between now and 1950 to assess the needs of their own children, and discover ways in which homes and schools, churches and towns, can do a better job—with youth themselves sharing in the planning.

In its 1948 program, the commission recognizes the principle that every child should have a fair chance—a right to care and protection and opportunities to become a good, self-supporting citizen. To this end, whenever community services or financial aid are needed they should be available, in all areas and to all children and youth.

We are learning what are the essentials in giving every child his chance. And we shall go on learning. But it takes time to put knowledge into practice. Again, services for children and youth can be spread only as fast as workers can be trained. Besides, some States and communities do not have financial resources or personnel to go ahead as fast as they might wish in making services available in all areas and to all children and youth.

For some children, and in some areas, we lag so far behind in making services available that the question we must face constantly is: "What children are we not reaching?" Children and youth in many rural areas, for example, have fewer health services and mental-health services, poorer schools and recreation, less social-welfare service, less vocational guidance and training than other children. And even in places where community services are well developed, there are some children and youth that the services reach infrequently, if at all, such as Negro children, those of Mexican parentage, and children of migratory agricultural workers.

In spite of many obstacles, we must push on for gains.

While we are planning for the children of the United States, we must do it in the light of world conditions. This was emphasized by the commission in its recommendations on international programs for children. In one recommendation the commission asked for support of the campaign to aid the work of the International Children's Emergency Fund and the American voluntary relief agencies. The fund-raising organization is called American Overseas Aid and United Nations Appeal for Children.

We who attended the 1948 meeting of the National Commission on Children and Youth have learned much through exchange of experience between the members from many parts of the United States. Now let us use our knowledge in raising the level of opportunity for children.

Katharine F. Lenroot

Chief, U. S. Children's Bureau

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APRIL • 1948

the CHILD

"ROOMING-IN" GIVES BABY A GOOD START

EDITH B. JACKSON, M. D., *Associate Clinical Professor of Pediatrics (Psychiatry) Yale University School of Medicine, Attending Pediatrician, University Service of the Grace-New Haven Community Hospital*

MORE AND MORE frequently joint conferences of various professional disciplines concerned with health are getting together to discuss their common problems and to work out ways of cooperating to promote the patient's health and satisfaction. These meetings show a need to discover ways of restoring something that was lost, or at least obscured, as the general practitioner gave way to the specialist. That something is the physician's professional attention to the personality of the patient.

Psychiatry, the youngest specialty of the medical profession, has picked up this neglected link—largely through psychoanalytic orientation. And with the help of psychosomatic medicine, the personal side of medicine is finding its scientific place among the various specialties.

Psychology and hospital care

What then, may I ask, are some of the psychological generalizations that are pertinent to the subject of optimal hospital care of newborn babies and their mothers? (I ask the reader's patience if for the moment the following items seem far afield.)

1. There is an alarming proportion of psychological illness in people of all ages. Physicians in private practice and those at out-patient clinics say that 50 percent or more of their patients suffer from some sort of emotional troubles. The number of men rejected as unsuitable for military service for psychopathological reasons lends forceful statistical support to such clinical impressions.

2. The emotional disturbances (personality disorders, neuroses, and psychoses) are as a rule rooted in early childhood; they develop according to the interplay of a fixed hereditary factor with the variable factors: (a) Stage of development, (b) environment, and (c) experience.

3. Emotional as well as physical development is individual, but ordered, with certain needs of the child predominating at various times. Satisfactory experience at each stage predisposes to the happy and successful adjustment at successive phases. Lack of satisfying experience, or injury, during any early phase interferes with the successful mastery of succeeding phases, and this leads to distortion or imbalance of reactions.

4. Injury to the developing personality may be caused by anxiety and guilt from within, and by pressure and denials from without, of a severity too great for a tender young organism to withstand. These may be listed as the child's fear of loneliness, his fear of loss of parental love, and his fear of punishment; and, also, parental expectations that the child live up to standards of behavior too advanced for his immature capacities.

5. The first needs of the child, according to present tenets, are: (a) Prompt satisfaction of hunger and of the urge to nuzzle and suck, (b) a feeling of warmth and support from the nurturing mother, and (c) peaceful, undisturbed rest between times.

Accordingly, the first injury that can be inflicted on the personality of the helpless infant is to refuse food and comfort when he needs it, or to force food upon him when he is not ready for it or already has had enough.

Repetition of such traumatic situations brings adverse reactions in both child and parent, and leads to later difficulties in the guiding and training of the child.

6. Children, however they may have been affected by the stresses of growth and environment, do in time become adults. And their adult reaction to people, to their work, and to their marital life and parenthood varies according to the way they have weathered, or succumbed to, the conflicts and hurts of growing up.

Hospital sets pattern

Hospital treatment of mothers and newborn infants has for various practical reasons tended to neglect variables. With routine separation of the infant from his mother, the above-mentioned infantile needs of the infant and the fundamental urges of normal, mature mothers to love, fondle, nourish, and watch their babies have been disregarded.

The hospitalization period, though short, has a far-reaching effect because mothers in general tend to follow the pattern of infant management set up in the hospital. They regard it as authoritative and more to be obeyed than their instinctive feelings (which may, indeed, have been squelched and belittled in childhood), more to be taken account of than the child's unhappy resistance.

There is thus a separate conflict for the parent and for the child in this opposition of authority to feelings, whose interaction stimulates a vicious circle of distress between them. If this is not broken by some concessions to the natural needs of each, there is breakdown somewhere.

At this point the pediatric-psychiatrist comes in as the mentor for parents who are at their wits' end with unmanageable children. His job is to trace the difficulties to their source in an attempt to restore balance, happiness, and health.

Through the mother's story, his attention is inevitably drawn to her uncertainties and perplexities since the time the child was born, to her lack of

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From paper read at the Third American Congress on Obstetrics and Gynecology in St. Louis, Mo., September 8, 1947, before a joint meeting of the hospital-administration, nursing, and public-health sections, on better maternal and newborn care. The panel included a contribution from an obstetrician, from a nurse, and from a pediatric-psychiatrist.

A mother cares for her baby at the George Washington University Hospital, Washington, D. C.

knowledge of what a baby really is like and what his characteristic changes are during development.

Inevitably he reaches the conclusion that the routine separation of infant from mother in the hospital, each being cared for as a separate assignment by separate nurses and separate doctors, is far from ideal; that it works deprivations for both mother and child; and that it certainly does not contribute to the mother's understanding of her child or to her new relationship in the family.

Why separate mother and baby?

Quite naturally the question has been raised: Why can't normal mothers who are looking forward to the care of their babies have them within sight and reach in the hospital (as well as at home) and learn by watching them, and under supervision, the first principles of infant care? Why not, indeed, if it is better for both mothers and babies? What can now be the justification for separating a mother from her healthy newborn infant? Why not have them in a room together? Dr. Arnold Gesell and Dr. Frances L. Ilg, working from the child-development point of view, came to the conclusion that mother and baby should be together, and in their book, "Infant and Child in the Culture of Today" (1943), suggested what they called a "rooming-in arrangement."

In following out this line of thought, different types of rooming-in projects are being worked out: For the maternity wing of the new George Washington University Hospital in Washington, D. C. [1]; in four Detroit hospitals, in single-room arrangements, through the mediation of the Cornelian Corner of Detroit, an organization composed of members of the medical and other professions concerned with social welfare [2]; and at the Grace-New Haven Community Hospital, in a four-bed rooming-in unit at the end of the maternity ward [3 and 4]. Dr. Henry L. Barnett has recently reported general observations from his 2 years' experience in the 12-bed maternity ward of the hospital at the atomic-bomb project at Los Alamos, N. Mex. Without discussing the reasons for undertaking this arrangement, he states that "the reactions of both the parents and the professional personnel to the arrangement as described were almost unanimously favorable" [5].

The rooming-in unit in New Haven has been in continuous operation since October 29, 1946, accommodating during its first 10 months 162 mothers with their babies.

The generally enthusiastic response of the parents to rooming-in is uncontrovertible evidence of some essential satisfaction it has afforded them. I believe this satisfaction will reflect essential benefits upon the children as they develop.

The nurses and doctors have also had great satisfaction in this unified service, which has in turn increased their ability to give sympathetic care to both mothers and infants.

Development of the plan in New Haven grew out of understanding cooperation between the department of pediatrics, the department of obstetrics, the school of nursing, and the hospital administration. A contribution from a commercial firm made possible the appointment of a full-time pediatric fellow and a full-time nursing fellow for conducting the work of the unit under the supervision of a committee whose members represent the cooperating departments.

The idea of a flexible modification of maternity and newborn care has met a ready response from mothers on various economic and professional levels, who have suffered some adverse reactions to their previous lying-in experiences, such as frustration, even bitterness (when they wanted to nurse the baby and were not helped to do it), and a general feeling of helplessness and ignorance on going home with the baby.

For fuller experience

Thus the procedures of the rooming-in project are based on the doctor's wish that the baby should have a fuller experience with the mother and the mother's wish to have fuller experience with the baby.

The procedures may be described as follows:

Every mother that is accepted for rooming-in is selected in the prenatal clinic on the basis of her wish to nurse her baby and her wish to keep him beside her after he is born.

Each mother selected is interviewed several times during the latter part of her pregnancy by a "rooming-in" pediatrician after her regular appointment with the obstetrician. The pediatrician tells the mother about the unit policies and encourages her questions, so as to relieve unnecessary anxiety and to direct her attention toward immediate plans for the infant.

The mother thus becomes acquainted with both the obstetrician and the pediatrician who will be in charge of her and her baby when she enters the unit.

Her husband is encouraged to be with her during the first stage of labor and to accompany her and the baby after delivery to the unit for a brief bedside visit. He may hold his baby, after putting on a hospital gown and washing his hands, at each of his daily visits during the 8-day hospital stay. He may learn to change the baby's diapers or to adjust him to the mother's breast if the baby demands a feeding while he is present.

There is always a nurse at hand, and the mother is free to request care for herself or her baby when she needs it or to take care of her baby herself when she feels ready. The baby may be moved to or from a cubicle nursery at the end of the room at any time, according to the mother's wish.

Only two people in addition to the husband may visit the mother during the hospital period, and only one person at a time. The baby is on the "ad lib" schedule and the mother also, to the extent that she need not be roused for the usual hospital routines. The unit is attractive, homelike, and quiet in atmosphere. The quiet is due not only to a sound-proof ceiling but to the general contentedness of the babies.

For emotional continuity

In selection of mothers for the rooming-in unit, priority has been given to those who want to nurse their babies. The unit policy of flexible schedules is particularly suitable to the mutual needs of the "nursing couple" (though the few non-nursing mothers that have been accepted have been equally appreciative of the arrangement). The emotional continuity or relationship between a mother's wish to breast feed her baby as a natural process, to keep him naturally close to her, and to have a natural childbirth has been noted by physicians and parents alike.

Of the first 100 mothers admitted to the rooming-in unit, 15, on their own initiative, which was stimulated by their reading, [*6*] requested the help of the obstetrician toward a natural, conscious, childbirth experience. Nine of these were successful with no anesthetic at all. From the pediatric-psychiatric point of view the importance of a mother's wish for conscious participation in the reproductive process cannot be overlooked. Mothers who choose to face the full experience of life without obliteration or denial are not likely to cheat their children of the truth. An honest environment without misrepresentation or false assurance is a most salutary influence for the growing child.

A 38-year-old mother expressed her appreciation of the supportive interview with the pediatrician at the prenatal clinic. This mother had had five miscarriages for no apparent reason, and had carried no previous pregnancy to term. She succeeded in carrying her sixth pregnancy to term and was admitted to the rooming-in unit. In a bedside conversation on the second day after the baby was born she spontaneously expressed her appreciation for the helpful interest of the rooming-in staff and told how much it had meant to her and her husband.

She recounted that she had been kept in bed for the first few months of this pregnancy, by a private physician, and that she finally came unwillingly to the prenatal clinic. She had felt distinctly mistrustful, because of her past experience with hospital clinics.

She hadn't dared to think of the baby as a real possibility. Only after the first interview with the doctor at the prenatal clinic in relation to rooming-in did she feel reassured, and for the first time, although she was in the eighth month of pregnancy, she and her husband began to talk about the baby, to admit his existence as a fact. She felt then that she had her own doctor and that the baby had his own doctor, too. We cannot concretely evaluate the meaning of sympathetic rapport between a prospective mother and her professional advisers. We may be content to say that it is immeasurable.

Play by play

One of the first private-status mothers to make application for rooming-in was an attractive, serious, and intelligent young mother of two children. She definitely wanted a different type of experience with this third baby—different from the experiences that she had had with the other two. Her reading and her associations had led her to believe in the value of natural childbirth, of breast feeding, of flexible feeding schedules for the infant.

Her labor was relatively short and entirely conscious. She described the delivery as follows in a bedside interview 3 days after the baby was born:

"It was very pleasant in the labor room—my husband and I talked. I didn't have any desire to shoo anyone away until just before I was taken to the delivery room, when the contractions came strong and close without distinction between.

"In the delivery room I kept waiting for the big one. I was relieved that I could ask questions and get answers. I never knew before what was going on. I was very surprised to find out about the blissful feeling of rest and relaxation between the bearing-down pains.

"In retrospect I am surprised that I was as alert as I was; I thought I would go vegetable, but I remember everything clearly. I couldn't believe it when the head appeared!"

According to an eyewitness account, when the delivery was complete she meditated aloud, "Well, I'm flabbergasted! If babies weren't so expensive, we could have one every year!"

The impressions of the husbands who share the wives' ideals of responding naturally as far as possible are also noteworthy. The next page presents the comments written by the husband of a mother who had experienced a successful natural delivery of their first baby.

The mother herself had written a play-by-play account of her labor for the obstetric-nursing supervisor, which began, "Isn't having a baby wonderful? Not just having him after he is born, but the whole process of his entry into the world," and ended, "If all women could go through labor with my experiences, I am sure they would agree that having a baby is wonderful." They both regretted that their husbands could not witness the birth of the child.

The husband wrote, "The thrill my

wife experienced from her labor had its counterpart with me. I say honestly that while I had secretly worried previously about her labor as I suppose all husbands do, I became so interested in it at the hospital that worry changed to the excitement of wonder and expectancy. Fortunately my studies [he is an educator] had led me to a fairly good idea of what to expect, and it was with great pleasure that each expectancy became real in its turn. My wife believes she enjoyed her labor because she knew what was happening. Estimating by conversation with other fathers in the ward, I should say that I, too, profited by being in on the mysteries of the process.

"Exactly how important it is that the birth was a pleasure to me I do not know. Conversely, however, I can imagine that the effect of a really unpleasant experience might be the seed of several later difficulties. . . .

"Events preceding labor were just as important to my wife as those that took place at the hospital. The preparation she had at the clinic was excellent. She started pregnancy with a thousand fears (which I shared). Gradually she reported these as eliminated. . . .

"Though this is not really connected with the delivery, I should like to say that rooming-in draws nothing but praise from me, and my wife believes the same. It is impossible for me to see how any other plan for maternity care in a hospital could ever have been permitted, let alone desired."

Enriched maternity care

In conclusion, I quote a letter from a relatively recent roomer-in—an entirely spontaneous communication. Since it summarizes the enrichment for maternity care which has been the goal of rooming-in procedures, there is little more to be added. The almost missionary fervor of the letter is characteristic of many of the mothers who have elected rooming-in. This must have a meaning. We shall have to ponder well its implications.

"Dear Doctor J: I have been trying to get a chance to drop you a note. I want you to know how much I loved your rooming-in project. Our baby is now 7 weeks old and doing wonderfully. I am still nursing her and have more and more milk for her.

"All the above, I am sure, is so wonderful because I was one of the few fortunate ones to try the project. It was wonderful. When we came home from the hospital we had no period of getting acquainted. Even though this baby is our first, I know the problems the girls who live near me have had. To quote one girl, she 'didn't know the baby cried. He never cried when he was brought in and out again.' Just two or three cases like that are just within calling distance, and I know how very fortunate I was.

"Several people have asked how I got any rest with the babies crying. They just don't understand that I learned to hear only my own baby and that when she cried I had all kinds of professional advice within earshot. That is a very satisfying feeling for a new mother.

Husband learns to hold baby

"I should mention my husband's feeling about the project. The night the baby was born he had the opportunity to hold her and then at every visit he held her. Besides being thrilled he learned how to hold her and was plenty of help when we came home. He held her as if he had been doing it all his life.

"I could go on page after page telling you how wonderful it is. I won't, but before I close I would like to mention the staff. It was also very wonderful to have a visit from you and Dr. O. every day. Any questions I had were answered soon after I thought of them, and sometimes they may have been very silly questions but they were all treated as though they were equally serious, and I had an answer given for each one I thought up. Since I have been home I have had three visits from the doctor, just to see how I am doing. So even anything that developed at home was soon cleared away.

"The nurses were certainly wonderful. Each one was full of life and fun, but when called upon for help were more than willing and did many extras for all of us. I never saw nurses who were so busy all the time and yet always willing to do another little thing to make one comfortable.

"The meals were wonderful. I was talking about dieting (just in fun) but every time the tray came in I had to admit the food won. We had little snacks between meals and it was just like being at home, raiding the refrigerator.

"Well, Doctor, I really must close, but I just want you to know how much I appreciate being chosen to try out the new project and I hope I can have it for each of my succeeding babies.

"Good luck, and I hope some day you will be able to enlarge your space and so accommodate everyone."

Mothers like rooming-in

It is clear that the response of the mothers to their experience in the rooming-in unit has been very favorable. The unified nursing care under joint obstetric and pediatric supervision is one of the important factors for the success of the undertaking. In its broader aspects the effort to supervise consistently both mother and child during pregnancy, during the lying-in period, and postnatally through visits to the homes, has helped to win the mothers' strong allegiance to the rooming-in project and their wish to encourage the expansion of rooming-in facilities. In fact, many mothers have shown a remarkable missionary zeal in this respect. It is my impression that rooming-in facilities should be available for all mothers who want it, but should not be pressed on mothers who feel opposed to the idea.

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WHAT SHALL I DO WITH MY BABY?

BERNICE R. BROWER, Director, Women's Service Division, United Charities of Chicago

WE, as social workers, have long felt that one of the most complex problems facing us is the task of helping the unmarried mother reach a decision about plans for the future care of her child.

Our close contact with the unmarried mother makes us quickly aware of the conflicts and anxiety that she feels when faced with the necessity of making a decision about her child; and her vital emotional stake in the problem is clearly evident to us.

At the same time, the worker is equally aware of what society as a whole feels about the problem, and the stake that society has in the future planning and well-being of the child, as well as society's concern with the problem of the unmarried mother herself, a concern which has been sometimes punitive and other times reformist.

Frequently, because of our understanding of the emotional disturbance of the unmarried mother, and our anger against the harshness of society's judgment, we have set out to combat these judgments by aligning ourselves with the client and sometimes even propelling her into a plan that ignored the basic factors in the situation.

In this way we sometimes impeded the ultimate adjustment of the mother and the child into society, despite the fact that we were so anxious to have society accept them.

Still later in the development of our professional skills, we became aware of a third stake in the problem—the stake of the case worker herself. We realized that our experiences and feelings toward our own parental relationships frequently colored our attitudes toward the mother and her child, and in many cases played a significant role in shaping the client's decision.

This growing awareness brought with it additional hazards in our work with unmarried mothers. In an effort to make certain that the mother was free to make her own decision uninfluenced by the attitude of the case workers, the worker also frequently failed to participate in this vital decision. And failing to give her client the necessary support, the worker left her to face the entire burden of the decision alone.

Our developing perspective on the problem has been shown in the historical pattern of dealing with the unmarried mother and her child. For many decades the foundlings' home was the major solution offered by society to rid the mother of the evidence of her guilt and at the same time to offer the child a chance of survival. But this was a harsh solution, wherein no heed was given to the needs of the mother, and the existence of the child in both physical and emotional aspects was grim.

Later, with the emergence of case work as a planned procedure, emphasis was placed on the desirability of the unmarried mother's keeping her child with her. This was in part due to the social worker's earnest desire to modify the harsh attitude of society, and in greater part due to the growing understanding of the importance of family life in the emotional development of the child.

Mothers who were undecided about plans for their babies were urged and encouraged to keep their babies with them.

Maternity-home procedures were planned so as to encourage formation of an emotional bond between mother and baby, and from this developed such requirements as compulsory breast feeding by the mother, an insistence that all mothers give personal care to their babies, and requirements that the mother and child live together in the maternity home for a stipulated period of time after delivery.

In our zeal to secure the advantages of a mother's love for the child, we tended to assume that the mere act of living together necessarily would give the child the security and affection that goes with satisfactory family living.

Many people today, both in social work and in the outside community, feel that the unmarried mother should be encouraged to keep her child, just as there are many people who believe that the only adequate solution for the future of the child of the unmarried mother is placement away from the mother in an adoptive home.

For a long time, however, most of us have been aware that neither of these answers can be applied in all situations. We have striven for our answers on a case-by-case basis, knowing that it was only through understanding the dynamics of each situation that we could determine the meaning that *this* child had for *this* mother, and thereby help her make a plan that would best meet her own needs as well as the child's needs.

We in Chicago have been giving a good deal of thought to the problem of helping the unmarried mother in her decision about the baby. An institute was recently held here under the auspices of the Council of Social Agencies, dealing with the problems that we are talking about today.

Do we emphasize mother or child?

In our planning for this institute, the members of the committee sat down together to discuss and clarify their own thinking about the relationship between the unmarried mother and her child, and to see what reconciliation would be needed between divergent points of view.

Since service to the unmarried mother is given by various types of agencies, we found that our thinking about the problem was frequently affected by the function of our own agency.

The major point of discussion seemed to be whether our primary emphasis lay with the interest of the mother or the child. Which of the two was the major responsibility of the agency? And upon which was the primary emphasis of our work to be placed?

As we talked further, the points of difference seemed to lessen and we emerged with the definite feeling that not only was there no single plan of action that was preferable in all situations, but also, except for rare instances, there was no basic conflict between the best interests of child and mother.

Given at the Minnesota State Conference of Social Work, Minneapolis, May 5, 1947.

We realized also that our best possibility for working out a sound plan for the future welfare of the child lay in helping the mother to work out her own problems, since it was only in this way that she could be free to make a sound plan for her child.

We have long recognized the complexity of emotions and behavior, and we know that for this reason the decision regarding the child could not be an isolated factor in the life of the unmarried mother.

We know that this decision would be influenced by the same emotional factors that had entered into the pregnancy and the total behavior pattern of the unmarried mother, and that it was through an understanding of these factors that we and she could best ascertain the meaning of the child to her.

We have seen this in many situations where a thorough exploration of the present situation has clearly indicated the inadvisability and even the impossibility of the mother's keeping her baby.

The mother herself has participated and is in agreement with this conclusion. Nevertheless, she finds herself completely unable to carry out the decision that she herself expresses as being best for herself and for her child. We know then, that reality for this girl contains other elements than those in her present life situation.

This does not in any way imply that external realities should not be given full consideration, or that they should not be presented by the worker and carefully explored with the mother. On the contrary, it is vitally important that this be done, since the girl herself may be so strongly motivated by inner psychological pressures that external realities have little meaning for her.

It then becomes the function of the case worker to help the girl understand the psychological pressures and to relate them to the realities of the present situation. We know that no plan can offer happiness for the mother or the child if the plan ignores the present reality, but it is important to expand our concept of reality so that it includes the psychological realities of the girl's situation as well as the external realities.

Let us briefly consider some of the plans that these girls bring to us.

Many of the girls who come to us state with fixed determination that they plan to keep their babies. Some of them have the backing of their families in this decision, and the circumstances of their lives indicate that despite many hazards the baby may have some degree of security in living with its mother.

Many more, however, have little mature warmth or security to offer the child, and the plan seems to offer serious disadvantages both to the girl and her baby. What, then, impels these girls to cling to their babies?

Dr. Margaret Gerard of the Institute for Psychoanalysis in Chicago recently pointed out that many of the unmarried mothers coming to us for help are impulsive and infantile individuals, whose own dependency needs may lead them to hold tenaciously to their babies. Sometimes this is because the girl feels that her family, or perhaps the worker, expects it of her. Or she may cling to the child through inability to relinquish any possession for fear that she may regret its loss at some time in the future. One factor that Dr. Gerard pointed out is of particular importance for us who must help the mother in making a decision.

Repeated experience has shown that the more dependent, immature women whom we know to be inadequate mothers practically always choose to keep their babies once they have seen and handled them. This choice grows, not out of an ability to care for the child, but out of the wish for pleasure for herself. We have all known mothers who, long after taking the baby, have found the difficulties which faced her overwhelming, and have come to us, saying, "If I only hadn't seen my baby I could have given him up." They have blamed the worker for not having helped them to make a plan that would have made this possible.

Medical social service helps

In Chicago we have been able to secure the cooperation of many of the hospitals in carrying out such plans, particularly those hospitals that have medical social-service departments. In these hospitals the mother does not have to see her child if she does not wish to, and in that case the baby is placed on a formula immediately after birth. This, of course, is done only with the mother's approval, and the baby is brought to her if at any time she changes her mind. In this way the girl has the support of her worker and the hospital in carrying through the plan that she basically desires, but which she might not be able to carry through if her feeling of guilt were increased by enforced personal contact with her baby.

Many other unmarried mothers need to cling to the child because of their attachment to his father, and the hope that through the baby they can still maintain a tie with him. Others who have been led into pregnancy as a result of their own disturbed family relationships, need to keep their babies as a help in working out these relationships. Some need to reinforce their dependence upon their families; others, to bring about their emancipation from an overly dominating family. The latter problem is illustrated as follows:

Dorothy J. was referred to our agency by a worker in the social-service department of the court, who felt that she needed help because she was greatly distressed over the pending adoption of her baby. This adoption had been privately arranged by Dorothy's physician, and she had already signed relinquishment papers before the clerk of the court. However, in the process of the adoption study which was being made for the court, Dorothy was interviewed and was most emphatic at that time in saying that she wanted to keep her baby and that she had signed the adoptive consent only because of coercion from her mother and the doctor.

She was under a great deal of tension when seen by our social worker and spoke with considerable excitement. She told of the pressure that had been put upon her by the doctor and her mother to consent to the baby's adoption, and of their threats to take her to court to prove her an unfit mother if she persisted in keeping the baby. She said that the doctor had even had telephone service cut off from her hospital room and had told her that she would not be able to go home with the baby unless she had money to pay the hospital bill and the bill for his services.

However, although she repeated her anxiety to keep the baby she could offer no tangible plan for his care. Dorothy was still living at home with her mother, and felt that it would be impossible for her ever to leave home. She was earning an adequate salary as a secretary, and felt that she could support the baby, but that it would be impossible for her to take him home because of her mother's opposition. There was some fantasy of a later marriage to the baby's father, but when this was discussed Dorothy herself expressed considerable distaste for such a marriage, feeling that the man was considerably beneath her, socially and educationally.

Since it seemed probable that Dorothy's consent had been obtained through duress, she was assured that legal assistance would be given through our legal-aid department. At the same time arrangements were made for her to have regular interviews with the social worker to help in making future plans. The worker felt that there was great conflict in Dorothy's mind about plans for the baby, despite her verbalized insistence on keeping him, and she felt that Dorothy's inability to consider tangible plans, as well as her need to remain in her parents' home, might indicate that she did not actually want to keep her child. What then was the meaning of this child to Dorothy, and why did she need to cling so desperately to him?

As the interviews progressed Dorothy was able to bring out a great deal of her feeling toward her family. As an only child she had been the absorbing interest of her dominating mother, a mother who at the same time had not given her a great deal of warmth. Her father was a pleasant but passive person who had played an unimportant role in the family, the same kind of role that the baby's father played in Dorothy's mind.

Mother has conflicting desires

The root of the conflict became more clear. She had a desire to emancipate herself from her mother's control and become independent, coupled with a desire to remain dependent upon the family and win her mother's affection in that way. This conflict had led to the relationship that resulted in her pregnancy, and also to her desire to keep the baby, against her mother's wishes.

As the interviews progressed, Dorothy herself became more aware of the confusion in her feelings toward her family, and her need to hold on to her child seemed to be decreasing. One day she spontaneously sent a letter to the legal-aid bureau attorney stating that she wanted to drop the action for the custody of the baby since she felt that the child would have no real security with her and would undoubtedly be better off with the adoptive parents.

She is still continuing her interviews with the worker, and although her relationships at home are not happy, she has shown a capacity for greater activity and increased friendships outside the home. This of course came about not only through her understanding of her own feelings, but also because the worker in many ways served as a mother substitute for Dorothy, a mother who was less restrictive and without need to control.

This may seem a strange case to present as an illustration of problems concerning keeping the baby, since it starts and ends with an adoptive situation. However, it is illustrative of the kind of motive that frequently impels a girl to keep her baby when she does not actually want him.

Adoption brings child some security

The next large group we meet is made up of girls who plan to have their babies adopted. Social workers always feel some security in dealing with this group since they know that if a placement is made through an authorized agency the baby at least will have some security for the future.

Sometimes, however, because of our reassurance about the baby we tend to neglect the emotional needs of this group of mothers. This is understandable in many ways since the pressure of work frequently forces us to use our time and effort on situations where the mother is undecided about plans and the future of the baby is in jeopardy. However, we are frequently surprised when all the plans are made, and the mother then changes her mind or is thrown into a panic of indecision. Sometimes this happens because we have not been sufficiently sensitive to her conflict about adoption, and have not helped her deal with her feeling of guilt. Sometimes, even when this kind of mother goes ahead with the adoption plan, her feeling of guilt may lead her into another pregnancy.

The extent to which this can be carried is shown in the situation of Gloria, an attractive, quiet, intelligent girl of 22, who came to us one summer asking for maternity care. She said that she was married and separated, but that her husband was not the father of the expected child. She told us that she had one son by her marriage, who was living with relatives of her husband. She spoke to the worker in a frightened tone, and looked as though she expected punishment or criticism. The worker quickly sensed her need for reassurance, and discussed practical plans for her. Before Gloria left that day plans had already been worked out for hospitalization, financial assistance, and living arrangements.

Later, in checking on the records of other agencies, we discovered that this was really Gloria's fourth pregnancy, and that all four pregnancies had been illegitimate. The first two children had been placed in adoption by an agency, and the third had been placed privately. The worker felt that with this secret standing between them there was no possibility of helping Gloria; and she told the girl what she had learned, but reassured her of our continued interest. At this point Gloria dissolved into tears and could not discuss it any further. She was not pressed to talk, and we continued to plan to help her.

In the third interview Gloria began to talk about wanting to keep her baby. She showed great distress over giving up the first child. The other two children seemed more shadowy in her mind, but the giving up of the first child was still so vivid that it might have happened only yesterday. It was agreed that the important thing was to work out the plan that Gloria really wanted.

There had been no security in Gloria's early family life. Her parents separated when she was only 2, and she was shifted from one relative to another, spending several brief periods with her mother. Records indicated that Gloria had suffered real cruelty from her mother. On one occasion the mother had burned the little girl's hand for a slight misdeed, and relatives stated that the mother had really tried to starve her.

There was also evidence that the mother was promiscuous, but she was also very hostile to Gloria because the girl had been involved with men.

Gloria had had a better relationship with her father's family, who had a more respectable status.

It seemed apparent that Gloria's relationships with men were largely on the basis of reaching out for a family relationship. Most of the men involved were older, and she spoke frequently of the kindness and consideration they had shown her, although for various reasons they had been unable to marry her.

Gloria kept her baby and gave him excellent and devoted care. Because of our concern over the welfare of the baby, as well as Gloria's past history, we discussed the situation with our psychiatric consultant. It was felt that the situation was hopeful, and that the girl was now reaching out for help because she had been allowed to keep her child.

In her mind the agency was not associated with the punitive, depriving attitude of her own mother. We had shown her by our attitude that we did not condemn her, nor did we see her as a worthless person; and because of this she was now able to reach out for help in other areas.

Gloria has continued under care, and now that her baby is older, plans are being made with her for vocational counseling, with the possibility of day care for her child when she returns to work.

Child's happiness at stake

The group that concerns us most is composed of girls who ask for long-time foster-home placement for their babies. These girls neither want to keep the children nor are they willing to give them up, but hold on to them through the nebulous tie of keeping them in foster homes. We are all aware of the unhappy situation of such children, children who grow up in a foster home, knowing their own mothers. These children are prevented from forming close ties with the foster parents, but at the same time do not get the affection and security that they crave from their own mothers. Frequently the child feels divided allegiance, and a rivalry is created between his own mother and the foster mother. As this goes on, the child may be impelled to repeat the neurotic pattern of the mother which had been the cause of the original situation.

As for the mother, this kind of solution has frequently enabled her to put off facing any of her own problems, because she is able to escape into this indefinite plan for long-time placement of the baby. In the past many agencies frequently entered on such planning without thorough consideration of all the motives involved. This is now less likely because of the extreme shortage of foster homes. This shortage has now forced us to sharpen our skills so that the foster home can be used to the best advantage. It is true, of course, that long-time foster-home care is sometimes necessary, but this is usually a last resort.

If we accept the basic premise that the focal point of planning is to help the mother meet and solve her own problems, what implications does this have with regard to the agency program and the role of the case worker? There are a great many implications to be considered: The first is the need for flexibility in the agency set-up. This implies flexibility both in legislative provisions and in agency procedures.

It is important that assistance and service be available for nonresident unmarried mothers, since the very nature of their problem, and their ultimate rehabilitation into their own group, frequently makes it necessary that these mothers seek help in a locality where they are known to no one.

It is also important that various types of living arrangements be made available to the girls. In many localities maternity homes are the only resource, although we know that many of the more disturbed girls are unable to adjust in a group and because their emotional needs are not met in such a situation they are not responsive to casework help.

Rigorous requirements for paternity hearings should not be insisted upon, since it is frequently desirable for the girl and for the future welfare of the baby that all ties with the father be broken. Unless the future welfare of the child seems seriously jeopardized, it is important that the mother be given the right to determine whether or not she wishes to institute such hearings. This is particularly important of course in situations where adoption is considered, since a clean break with previous ties is clearly indicated here.

In considering the role of the social worker it is important that she be prepared to accept her own responsibility for helping the unmarried mother reach her decision about the disposition of the child.

Worker should not shirk duty

In our eagerness to permit our client the right to self-determination, we have frequently avoided our own responsibility in helping her to face one of the most vital problems that a girl can be called upon to meet. In many records we read such examples as the case worker who insists upon discussing alternate plans with the girl who has already resolved upon adoption for her baby, thereby confusing the girl and making her feel that the case worker, and therefore society, looks upon her as a bad mother for wishing to give up her child. We have all also read records where the mother specifically asks the case worker for advice and counsel, only to be turned aside by the worker who states, "It's all up to you."

We have all learned that one of the most important tools of case work comes through the relationship that is developed between the client and the worker. If we accept this premise, how then can we remain aloof and apart from so vital a decision? It is important to realize that any decision which the girl makes will have some painful aspects, and that it will be necessary to help her work through the feelings that may arise before and after her decision. It is also important that we fully convey to her the fact that even if she does not make the decision that we feel is best, we are still interested in her, and she can still turn to us for help.

The responsibility for making a decision for the future of an unborn child is indeed a grave one. We are all awed by the consciousness that here is an individual who as yet has been untouched by the problems of the world. What will his future be, we wonder? But as social workers, we have always had to carry grave responsibilities, and if the great amount of thinking that has recently gone into this problem is any indication, we will not hesitate to meet these responsibilities in their turn.

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CHILD'S MENTAL HEALTH CAN BE FOSTERED

HENRY H. WORK, M. D., *Director of Mental Health Unit, Children's Bureau*

"WE have been educating for this war for 40 years," said a European physician to Dr. C. Anderson Aldrich during a wartime conversation. "The way we have cared for our babies and young children has encouraged the kind of personality that makes violent conflict inevitable."

Much of recent medical thought in this country is in agreement with this opinion. Physicians are realizing that a great deal of the advice that has been given to parents on the rearing of their children has led to damaged emotional health in both children and parents. Recent psychiatric investigations have taught us a bitter lesson about our methods of bringing up children.

How did these methods get started? And why is our progress in such fields as child nutrition in danger of being negated by our failures in applying our knowledge? What does it profit us to know what foods children should eat if they refuse to eat them? Perhaps study of recent errors can point to a solution of this problem.

At the turn of the century, scientific knowledge was growing rapidly. Doctors were beginning to learn what nutrition means in animal life. It was necessary, however, to study the effects of vitamins and minerals in the growing human as well as in the laboratory animal. Children, above all, stood to benefit by the application of this knowledge.

But in applying the knowledge, we adhered too rigidly to the methods that had been so valuable in establishing the importance of nutrition in growth. Into the discard went fulfillment of the emotional needs of the infant, or of the desires and abilities of the parents. The clock became the guiding beacon of infant care, and the measured ounce the talisman.

Now another generation of physicians is reaping a harvest of feeding problems that were planted by that rigidity.

For unfortunately admiration for the niceties of the laboratory schedule had spread to other factors in the relationship of parents and children and the method was applied to all aspects of this relationship.

A baby gets not only physical joy from his milk, but emotional satisfaction through sucking.

The child born in the hospital was taken from the mother soon after birth. If she was not actually discouraged from breast feeding, she did not receive much encouragement. Babies were weaned at earlier and earlier ages. And little children underwent early and sometimes vigorous toilet training.

These deviations from the familiar relations between the mother and her child produced changes in the child's growing personality and disturbance in his behavior.

It is hard on those of us who are concerned with the care and well-being of children to have the defects in our approach pointed out to us.

But we must admit, not only the increase in psychiatric problems relating to children's sleep, feeding, and bowel and urinary functions, but also the increase in frustrations that result in tense mothers and confused fathers.

What can be offered as an approach to a newer understanding of these problems? Shall we say that our recent knowledge leads us back to older methods? This recent knowledge derives not only from psychiatrists' studies of people of all ages, whose personalities have become warped, but also from a slowly growing but abundant fund of information on the growth and development of children. Let me emphasize that this field takes as much account of the changing emotional picture of the child as it does of his increase in height or weight. All these studies point in various ways to new feelings for the mother-child relationship, or perhaps a restoration of them. They emphasize that no one factor of this relationship is of exclusive importance—that it is futile to consider the relationship from any single point of view.

Let us look at three broad aspects of this relationship.

The first concerns the growth of the child's abilities, and our part as parents in helping him to use them. Nobody expects a newborn to sit up or a 6-month-old to walk. But many of our practices in feeding babies and in teaching them to control the bowels and bladder repeatedly violate the principle that trying to teach a child before he is ready to learn is a worthless procedure at best. Our current knowledge suggests that it may be harmful as well.

Elizabeth can feed herself, but she is glad to have mother help with the last few spoonfuls.

Those who study the development of the body have shown us that the nerves develop slowly and that, until a connection has been established between a nerve and a muscle, the muscle will function badly or not at all. Once this nerve-muscle unit is complete, however, it is ready to learn its function in terms of the body as a whole.

A second aspect of change in the child is also involved with development; it is the change in the child's emotional outlook as he becomes daily more mature. The change is apparent as the child learns gradually to control the combination of fear and anger that he shows in early infancy whenever anything displeases him.

Again, our recent knowledge suggests that the baby's pleasure in getting his food includes more than physical joy in the milk; it includes emotional satisfaction in the act of sucking. When properly satisfied, this desire to suck diminishes; when this satisfaction is abruptly or forcibly denied, the urge may be turned into other channels. Although not every child who sucks his thumb has been subject to weaning difficulties, prolonged thumb sucking is frequently associated with such difficulties.

Thirdly, we must pay more attention to the change in the child's attitude toward the mother and in her appreciation of this. Everyone is aware of the total dependence of the newborn. Not so easily apparent are the subtle changes in the direction of the child's independence, which will some day culminate in his establishment of his own home, as an adult. Mothers vary greatly when it comes to relinquishing their desire for their child to depend on them. A few are never able to allow him to go free, and they blight his establishment of real adulthood. Or they give him too much independence, which may lead to his becoming devoid of any conception of the rights of others.

How, then, can we utilize our current knowledge in all these fields to foster stable personalities by giving a baby a good start in the earliest relations with his mother? One thing we can do is to encourage in every way the closeness between the mother and her child that was characteristic of earlier generations, applying to this relationship all we know of the child's growth, his development, and the changes in his emotional patterns.

An early step toward encouraging this beneficial closeness between mother and baby is described in this issue of *The Child* by Dr. Edith B. Jackson (pp. 162–165). Under an arrangement called "rooming-in," the hospital, instead of separating mother and newborn baby during the postnatal period as a routine measure, permits the mother to keep her baby near her. Such an arrangement gives the mother-child relationship an auspicious beginning.

We physicians can help this good relationship by not pushing either the child or the mother beyond their abilities, but instead recognizing that as the child grows his independence should increase. This will bring new responsibilities to the mother in satisfying his desire to learn and in encouraging his need for freedom. We must realize that a good relationship between mother and child must develop with his increasing needs rather than according to any standards that fit an experimental situation.

This attitude on the part of the physician, without urging an empty, or hostile, attention on the part of the mother toward the child, would foster a valid affection for him. Such affection should minimize friction, and subsequent frustration, and should breed respect on the part of the child.

If we can thus do something to eliminate the need for stern methods of discipline, we shall have made a beginning in educating people to live together in peace.

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COUNCIL ASKS BETTER DEAL FOR MIGRANT WORKERS AND FAMILIES

"A SIZABLE SEGMENT of our population, through community and State neglect, has been robbed of so many normal American and human rights that it is almost unbelievable. Child labor, substandard living, and a padlock against education have destroyed the rights of children and drastically disturbed the integrity of family life among migrant workers."

These words, from the Report and Recommendations of the Federal Interagency Committee on Migrant Labor (1947), describe some of the conditions that the National Citizens Council for Migrant Labor has been formed to work against.

The council, which was formed in October 1947, is composed of individuals and of National, State, and local organizations. It expects to stimulate and assist in the establishment of regional, State, and local citizens' councils and to work with them toward improving the conditions under which migrants live and work. It recognizes the need for a comprehensive, long-term farm-labor program, which will include migrant workers.

Formulation of such a program, the council believes, should lessen the need for migrant labor through greater diversification, both in individual industries and on an area basis, and through greater use of local labor. The council calls on employers and public and private agencies and organizations to help in making this long-term program possible.

The council will be concerned with administrative policies of Federal, State, county, and local governments, with Federal and State legislation, and with the work of both public and private agencies insofar as they affect migrant workers and their families. Migrant labor, says the council, is cut off from most of the rights and privileges which other American workers enjoy. And the council will work for extension of all such rights and privileges to this group of workers and their families.

We present here parts of the council's program that concern children:

Recruitment and placement of migrant workers

The first need of migrant, as of other labor, is work. But the difficulties in finding work are much greater than are those of more settled workers. The migrant worker can, if he is not well informed as to where work is, waste a large part of his already irregular working season in wandering from place to place. Employers need migrant workers. It is essential that the employer, the migrant worker, and both Federal and State agencies work to use this shifting labor force to the fullest. This means that the worker must be told in advance where he can find work; he must be informed as to what the working and living conditions will be; how long the work will last; where he can go next in his migration. This is unquestionably the most difficult recruitment and placement problem in the United States.

* * * * *

The United States Employment Service needs sufficient funds to extend its regular services to all of the labor market areas and key points along the routes which migrant workers travel. Placement of migratory workers is not a job which can be handled from established offices alone. Greater effort should be made to transfer workers from agriculture to industry and back again as seasonal demands develop.

Child labor

It is quite customary for even very young children of migrant parents to work long hours in the fields. To prevent this, State child-labor laws must be extended to cover employment in agriculture. The child-labor provisions of the Fair Labor Standards Act should also be made to cover children in industrialized agriculture. In addition, State school-attendance laws must be extended and enforced.

Education

At present children of migrant families are denied the educational advantages which children of more settled parents enjoy. This is due not only to the nature of their parents' occupation, but often also to community attitudes which make these children unwelcome in the schools, and to the fact that many schools are not prepared to meet the special needs of migrant children. Both Federal and State aid, in money and in planning, are necessary if local communities are to give these children equal educational opportunities. The council will work for:

Admission of migrant children of school age to local schools.

Provision of extended school facilities, summer programs, parent education, specially devised units of study for migrant children.

Requirement of the same school attendance of children of migrant families as of the children of permanent residents. Provision of such State and Federal aid as will be needed to make available equal educational opportunities to children of migrant families.

Child care and youth program

Child-care centers for migrant children are needed. Nutrition, education, and feeding programs should be instituted. These services must be integrated with the basic health, welfare, and education programs of local communities.

Health

The council will sponsor a bill to provide medical, hospital, dental care, and drugs to migrant workers and their families, by Federal grants-in-aid to States. There are many rural counties in which migrant workers are employed which do not yet have preventive public-health services. Such services need to be extended to all of these counties.

* * * * *

Housing

The insanitary and dangerous housing often furnished migrant workers and their families constitutes one of the major problems of these workers. Beginning in the 1930's the Federal Government undertook the establishment of labor camps in the major crop areas. That program is now being liquidated and the camps are being sold. There is danger that they will be sold to associations of growers, and form part of a company housing program. The council endorses:

Sale of the federally owned camps to State or other public or semipublic agencies, unless and until they are restored to Federal operation.

Reestablishment and extension of the Federal labor-camp program.

Enactment of State laws requiring licensing and regulation of private labor camps.

Inclusion of rural housing in public-housing programs.

Labor contractors

Licensing and regulation of private employment agencies, including labor contractors, by State and Federal laws are needed.

Transportation

Migrant workers are often transported long distances under dangerous, unhealthful conditions. They are often transported by the labor contractors who act as their representatives in dealing with employers. The council favors extension of the Interstate Commerce Act to give the Interstate Commerce Commission jurisdiction over private transportation of workers from State to State, as well as regulation of intrastate transportation of workers under State laws.

Wages

Migrant labor is for the most part unorganized. It is not now adequately protected by either Federal or State wage laws. Ill-informed, pressed always by immediate need, employed only part time, migrant workers are not able to earn enough to support themselves and their families in decency. The council wants to see the Federal Fair Labor Standards Act extended to agricultural workers, and State laws adopted to provide for prompt and regular payment of migrants' wages in cash, and for collection of unpaid wages.

Workmen's compensation

Migrant workers, except for those in one or two States and Territories, are not now eligible for workmen's compensation. But the accident and death rates in agriculture are as high if not higher than those in other major industries. The council believes that State workmen's compensation laws should be extended to agricultural workers and that minimum premiums should be reduced to employers so that agricultural workers may have the protection of insurance covering small numbers of workers and for short periods of employment.

Home, sweet home, for this mother and her family is nothing but a succession of tents, shacks, and other so-called shelter. Housing is one of the worst problems of migrant laborers.

Social security

A sizable group of workers, needing the benefits of social insurance if they are ever to better their conditions, are now denied that help. The Federal Social Security Act must be extended to all migrant workers, including the benefits of unemployment, old-age, and survivors' insurance, and public assistance; removal by States of residence requirements as a condition of such benefits is also essential.

Unless all groups concerned in the migrant labor situation — employers, the workers themselves, local communities, local, State, and Federal Governments, public and private organizations, and interested individuals—work together, the conditions under which migrant workers and their families work and live will remain shocking and contrary to what we consider the rights of every American citizen.

Reprints available in about 5 weeks

Another move for these children of migratory agricultural laborers. What will their new location have for them in educational opportunity and in health and welfare services?

• IN THE NEWS

Act of Congress Authorizes International Cooperation in Work for Children

When President Truman on January 27 signed Public Law 402, often referred to as the Smith-Mundt Act, legislative authority became available for a broad program of cooperation and exchange of information between the United States and other nations of the world. In other words, the United States will be able to carry on, in collaboration with the nations of Europe, the Near and Middle East and the Far East, joint projects similar to those which have been developed with such outstanding success in cooperation with the other American Republics.

Plans already are under way for expansion of the program from hemispheric to global proportions. Exchange of information and experience in the fields of maternal and child health and welfare, at the request of governments other than those of the American countries, now has definite legislative authorization. Expressions of interest in this type of cooperation began to reach the Children's Bureau even before final passage of the act, furnishing additional proof of the fact that the health and welfare of the younger generation is a primary concern of people everywhere.

Following the pattern already well established in this hemisphere, where agencies of the Federal Government are cooperating with their counterparts in other American countries, under a program coordinated through the Interdepartmental Committee on Scientific and Cultural Cooperation of the U. S. Department of State, doctors, nurses, social workers, nutritionists, and specialists in many other fields of work for mothers and children, may be sent to other countries on request. Other nations may send similar specialists to the United States. From this sharing of information, experience, and skills, will come greater understanding among the peoples of the world, enrichment of our respective cultures, raising of professional standards in many fields and, above all, greater benefits to children everywhere.

Elisabeth Shirley Enochs

Recommend Plans for State and Local Action

Every State and Territory, and every large community, should have a representative body planning in behalf of children and youth. This was recommended by the Conference on State Planning for Children and Youth, which met at Washington March 30–April 1, convened by the National Commission on Children and Youth and the Children's Bureau, to plan a 2-year State and local program of preparatory action prior to a 1950 White House Conference on Children.

Two hundred and fifty State officials and leaders, representing all but two of the States and Territories, attended the conference.

Pointing out that each State will need to work out its own pattern for planning groups, the conference recommended that three types of such groups be considered: Those organized by legislative authority, those organized through Governor's appointment without legislative action, and those organized under voluntary sponsorship.

Whatever the type, the conference recommended that the planning body should be composed of representatives of established organizations, including public and private agencies, and individual citizens as well. It should be large enough to permit all groups in the community to be represented on it.

In order that the planning body may fulfill its broad purposes and also its specific objectives, the conference recommended that in general its functions include: (1) Fact finding; (2) assessment of facts; (3) acting as a clearinghouse for information; (4) interpreting over-all needs of children and youth and services to meet these needs; (5) planning for and promoting legislation; (6) participating in national planning groups and programs for children and youth, such as the White House Conference of 1950; and (7) coordinating services and programs for the well-being of children and youth.

Further information concerning the Conference on State Planning for Children and Youth will be given in a future issue of *The Child.*

Communities Observe National Boys and Girls Week

"Youth—Key to the Future" is the theme of the twenty-eighth annual National Boys and Girls Week, which will be observed April 24 to May 1, 1948. Boys and Girls Week calls attention to the organizations and programs serving the needs of youth and seeks to arouse the interest of the entire community in supporting measures to strengthen and ensure the wholesome, purposeful development of all boys and girls.

For Training Health Personnel

In an effort to meet the great need for doctors, nurses, medical social workers, nutritionists, and dentists, to take part in carrying out the maternal and child-health and crippled children's program under the Social Security Act, funds under the act are now budgeted to the amount of more than $1,500,000 for training these types of personnel.

Approximately half of this amount is being expended by State agencies for stipends, tuitions, and travel of trainees, and the other half for development of postgraduate courses at educational institutions.

Some of these postgraduate courses, the plans for which have been developed jointly by the educational institutions, State agencies, and the Children's Bureau, are as follows:

In the field of medical social work, courses have been, or are being, established at Tulane University, University of Chicago, Boston College, Boston University, and Simmons College.

Nursing courses have been, or are being, established at the University of Colorado; Charity Hospital, New Orleans; Indiana University; Wayne University; the University of Cincinnati; Meharry Medical College; Vanderbilt University; the Johns Hopkins Hospital; Columbia University; and Boston University.

In the field of public health, maternal and child-health courses have been strengthened at the Harvard School of Public Health, the Johns Hopkins School of Hygiene and Public Health, and the University of California School of Public Health.

Medical education, undergraduate and postgraduate, has been strengthened at the University of Colorado, the

University of Nebraska, Louisiana State University, Meharry Medical College, the University of Arkansas, the University of Tennessee, and the Johns Hopkins University.

Postgraduate courses in children's dentistry have been established at Meharry Medical College and the University of Tennessee.

At Western Reserve University provision has been made for supervision of field training for postgraduate nutrition students.

Academy of Pediatrics Issues New Monthly

Beginning with January 1948, the American Academy of Pediatrics is publishing a monthly called *Pediatrics*, owned and controlled by the Academy.

According to its announcement, *Pediatrics* publishes papers on scientific and clinical investigation in the field of pediatrics. It also includes papers on public health and preventive medicine, genetics, nutrition, psychology, education, social legislation, nursing, and sociology, when the subject matter is related to child health and welfare. *Pediatrics* is the medium of expression of the Academy to the medical profession and to the public. Contributions dealing with special spheres of interest to pediatricians are published in feature sections.

To Study Effects of War on Children

A research grant of $20,000 has been awarded, upon the recommendation of the National Advisory Mental Health Council, to the International Committee on Mental Hygiene to study the effects of war on children. This study will be made under the direction of Dr. David Levy and will be presented at the International Congress on Mental Health to be held in London in August 1948.

• FOR YOUR BOOKSHELF

CITIZENS LOOK AT EDUCATION; a progress report by the Citizens Federal Committee on Education, 1947–48. Prepared by the Subcommittee on the Teacher in America. Federal Security Agency, U. S. Office of Education. Washington, 1947.

The present school year marks the beginning of a turn for the better in education in the United States, says this report. There is abundant evidence that the ominous deterioration of our educational system has been arrested. The public has become aroused to the danger threatening our schools and in many places has acted decisively to improve conditions.

In order that the gains of the past year may be placed in proper perspective, the Subcommittee on the Teacher in America offers this progress report which stresses what remains to be done, and recommends that the individual citizen do four things for improvement of the schools: (1) Check up on educational conditions in your own community; (2) Work with organizations seeking to improve educational conditions; (3) Get to know your children's teachers and show them they have your understanding, friendliness, and support; (4) Encourage able young people to consider teaching as a career.

MONEY MANAGEMENT: CHILDREN'S SPENDING, by Martha Bennett King. Household Finance Corporation, 919 North Michigan Avenue, Chicago 11, Ill., 1946. 40 pp. 5 cents.

Fourteen persons eminent in various pertinent fields were consulted in the preparation of this booklet, as well as many references on the subject. Despite the fact that one of the few studies on children's use of money, that of Dr. Esther Prevey, does not appear to have been used, the good sense and practical experience of those whose ideas are synthesized in the pamphlet, make it a most desirable contribution to parent education.

Every question and objection that parents ordinarily bring up about their children's handling of money is taken up reasonably and practically, and the reader is persuaded right on through to the end by the lively format and illustrations. The author's humorous touches should do a lot toward helping parents to accept some ideas they might otherwise reject or take too seriously.

Marion L. Faegre

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A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had without charge.

The California Hearing Conservation Program. By Jessie M. Bierman, M.D. and Donald R. Caziarc. *American Journal of Public Health*, April 1947.

Formula Room Experiment in Terminal Sterilization. By Robert H. Lowe, M. D. *The Modern Hospital*, August 1947.

The Newborn: His Family and the Modern Hospital. By James Clark Moloney, M. D., John C. Montgomery, M. D., and Genevieve Trainham, R. N. *The Modern Hospital*, December 1946.

Psychiatric Consultation in Case Work Agencies. By Jules V. Coleman, M. D. *American Journal of Orthopsychiatry*, July 1947.

The Public Health Nurse and the Emotions of Pregnancy. By Kent A. Zimmerman, M. D. *Public Health Nursing*, February 1947.

Responsibility for and Use of Interim and Emergency Placement. By Leon H. Richman. *Social Service Review*, September 1946.

What Preparation Should an Institution Give a Child for Better Living in a Community? By Frederick G. Behrends. *Tennessee Public Welfare Record*, June 1947.

• CALENDAR

Apr. 24–May 1—National Boys and Girls Week. Twenty-eighth annual observance. Further information from the National Boys and Girls Week Committee, 35 East Wacker Drive, Chicago 1, Ill.

Apr. 25–28—International Council for Exceptional Children. Twenty-fourth annual convention. Des Moines, Iowa.

May 1–2—Society for Research in Psychosomatic Problems. Atlantic City, N. J.

May 1–4—National Health Assembly, Washington, D. C.

May 5–8—National Conference on Family Life. Washington, D. C.

May 7–8—American Council on Education. Thirty-first annual meeting. Chicago, Ill.

From May 10—Population Commission. Third session. Lake Success, N. Y.

May 16–19—Third National Citizenship Conference. Sponsored by the National Education Association and the U. S. Department of Justice. Washington, D. C.

May 19–22—American Hearing Society. National conference and annual meeting. Pittsburgh, Pa.

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FOR HUNGRY CHILDREN

Millions of children overseas are hungry, cold, and sick because there is not enough money to feed them, clothe them, and relieve their suffering.

For the sake of these victims of war, the American Overseas Aid-United Nations Appeal for Children is asking each of us in this most fortunate country to give as much money as we can. We are asked to give a total of at least $60,000,000.

This sum, plus what the United Nations Appeal for Children is collecting in a number of other countries, will bring food, warm clothes, and some medical care to large numbers of children who are now hungry and shivering, and—many of them—ill.

Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, has seen many of these children. Dr. Eliot was on loan to the International Children's Emergency Fund for 4 months last year as chief medical consultant, and spent 11 weeks visiting ravaged European lands.

After her return Dr. Eliot said: "Conditions have grown even worse for children this winter, because of the extensive drought during the summer and fall, and because all UNRRA supplies are exhausted. Governments are struggling to feed, clothe, and give medical care to children, but some 30,000,000 are in urgent need of food, especially milk, fats, and proteins. The situation in many places is desperate."

Other observers have found the same conditions. I myself had first-hand contact with some of these conditions when I went to Europe last fall to attend a meeting of the Executive Board of the United Nations International Children's Emergency Fund.

Only a fraction of the children who need food, clothing, and medical care are now receiving it, although the UNICEF and many voluntary relief agencies are doing all they can with the money they have.

The UNICEF has already made provision for nearly 4,000,000 children and nursing mothers in 12 European countries to receive supplementary foods, usually as part of a daily meal, including special protective foods (milk, fats, and cod-liver oil, and some meat); UNICEF is also planning to aid Chinese children. Its support comes largely from 16 governments and from the residual assets of UNRRA, and this will be supplemented by funds from the world-wide appeal now under way. The various foreign-relief agencies supported by voluntary funds are also aiding large numbers of children overseas.

The President of the United States has made his appeal to all of us. "In contributing to American Overseas Aid and the United Nations Appeal for Children," President Truman has said in a letter to Lee Marshall, chairman of the Board of Directors of AOA–UNAC, "thoughtful Americans will be giving an effective demonstration of their traditional humanitarian concern for the welfare of people in distress and providing an example of our democracy in action.

"The United States Government," he points out, "is doing what it can to promote the economic rehabilitation of a number of countries which have indicated a willingness to help themselves to the best of their ability. Through American Overseas Aid, the American people have an opportunity to back this policy with voluntary support for private agencies which, over a period of years, have proven their effectiveness in the field."

In concluding, President Truman writes: "I am convinced the American people are determined that the world's children shall have at least a chance to survive and I know of no better way of transforming that determination into action than by supporting American Overseas Aid and the United Nations Appeal for Children."

Let us give the world's children at least a chance to survive.

Katharine F. Lenroot

Chief, U. S. Children's Bureau

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the CHILD

A NEW LOOK AT CHILD HEALTH

BROCK CHISHOLM, M. D.

Executive Secretary, Interim Commission World Health Organization

IN speaking to you here at the National Health Assembly, about the "new look" in child health, I am very happy indeed to be given the opportunity. I appreciate this greatly as a gracious gesture to the new, very young—in fact, not yet quite born—World Health Organization. However, this new look, not so well known actually, predates the other well-known new look which is in the process again of changing the surface contours of the female species.

This new look that I am going to tell you about began something over 2 years ago at a technical preparatory meeting in Paris held to draft the constitution of an international health organization. The conditions of the world were changing rapidly at that time. This was recognized by these people who met together.

At an international health conference in June and July of 1941, 61—and since then 3 others, making a total of 64—nations signed the constitution of the World Health Organization. Incorporated in this constitution is the new look in child health.

Health gets new meaning

The beginning of that new look is shown in the first statement in the constitution, which is a definition of health. Never again will the makers of dictionaries have to worry about the meaning of this particular word. The exact meaning is now agreed on officially by 64 nations. Perhaps no other word has been so successfully and completely defined as this word "health." I would remind you that any change in this definition will require a two-thirds vote of the nations. So we may with confidence say there is one word in the English-American language whose proper use and whose proper definition we can be quite sure of.

Health is defined as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity.

This is the new look. This is a recognition by 64 nations that the necessary equipment of the individual has changed, that never again can we regard people who merely have healthy minds in sound bodies or who enjoy only physical health as being healthy. Never again can such people be considered truly healthy.

The requirements for health now go beyond the old definitions. It is recognized that a necessary part of the equipment of every human being is social health, the ability to live in harmony with other people of other kinds, with other traditions, with other religions, and with other social systems, throughout the world.

A little later in the constitution of the World Health Organization there is another statement which I might read you. "Healthy development of the child is of basic importance. The ability to live harmoniously in a changing total environment is essential to such development."

That is a statement, again, which was signed by 64 nations. There is no doubt whatever as to its meaning. It means that we, all of us, need to take a new look at the way our children are developing. Unless we are very careful, very careful indeed, and very conscientious, there is still great danger that our children may turn out to be same kinds of people we are. There could be nothing more disastrous than that. We are the kinds of people who have got the world into the mess it is in now. We are the kinds of people, as all our ancestors have been, who fight each other enthusiastically every 15 or 20 years and have done so throughout all history of the human race. Until quite recently that fact was of relatively little importance. When people used to fight each other, ordinarily only a few thousand or a few hundred thousand or occasionally a few million people were killed. Times have changed. The efficiency of killing now available to the human being has changed the very conditions of survival in the world. The new and efficient methods of killing—the atomic bomb, and far beyond that the horrible potentialities of biological warfare—have produced a world situation where it becomes quite clear that our previous methods of competitive survival have become utterly obsolete. It is quite clear now that warfare and suicide are synonymous terms.

Children need new patterns

It is quite clear that we must learn to live in peace with each other throughout the world. If we do not do so, there is little prospect that our children will finish their lives according to the statistical probabilities on which the life-insurance companies depend. In fact, there is little prospect that any but a few of our population, a very small minority, will survive the next 20 or 25 years if we go on being the kinds of people we have been, and if we allow our children to reproduce our patterns.

It is well worth our while to look at the way we were brought up, the way we were developed, and hope to find out what is wrong with us so that we may prevent our children from assuming those same patterns.

There are certain things that are clear now about the development of children. It is clear that there are enormous numbers of adults in the world who lack security, who have lacked security from infancy, and because of that lack of security are available as followers specifically of those people who have excessive needs for power, who have neurotic needs for leadership, who have vast needs for individual personal importance and prestige. There will always be such people. We can take it for granted that there will be a continual crop of neurotics in the world for quite a long time yet. They are the potential leaders in strange and weird directions, but it is time to begin to do something about the masses of people who up until now have been available as followers of such people.

It becomes clear that the first necessity is to produce a degree of security

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Given at the National Health Assembly, held at Washington, D. C., May 1–4, 1948.

in small children that will make it unnecessary for them to search for security in peculiar and unworkable ways when they become adults. Some healthy conditions of security are rather well known. I think it is clear to all of us that the first and primary necessity for finding security on the part of the human being is complete security in small infancy. Complete security in infancy does not depend even on adequate food supply or shelter. There is only one thing on which it does depend to the most important degree: unquestionable, all-embracing, obvious love, and nothing else will give a small child that degree of security on which he can build his citizenship, from which he can afford to adventure into a perilous world. If he does not get it then, he will spend the rest of his life searching for it, and searching for it in strange places where it is not to be found. This, then, is the first reckoning.

Complete security for a small child depends on our unquestionable, all-embracing, obvious love.

Second, the child must have the opportunity of growing into a pattern, but not by precept. There is no use whatever in lecturing children about their responsibilities and where they must go. There is only one way in which a child grows into a pattern, and that is by identifying himself with an elder person, a person whom he admires and loves. And so the responsibility of parents and teachers of young children is to show children in their own persons and in their own habitual patterns the kind of citizenship that will make it possible for the human race to survive in the future. That has not been done widely in the past.

A child develops in time and space

If the child has the opportunity, he will begin very early a progressive development which will continue throughout his life, but this progressive development may be stopped at any stage by a variety of circumstances. The most common is a lack of pattern close to him which will show him the potentialities in the future.

If a child is developing normally, he will develop mostly in space and time. He will find himself first as a person when he is very small. At first he has only feelings which are unrelated to time, space, or person, but gradually he learns that he is a person experiencing. He learns something of space. He learns that there are other places beyond his reach. He learns to affect his immediate environment and then his further environment. He learns there are other areas that are not within his immediate purview. He learns there are other people in his environment. He learns about other members of his family. He learns to adjust to those other members and to demand, to a degree, that they adjust to him.

If he is developing soundly, he very soon develops a relationship, or potential relationship, to other members of his community, which at first is very small—only his own family. But when he is very young he should be, if developing soundly, developing a responsibility toward other members of his family. I remind you again that he cannot be beaten into doing this. There is only one way he can learn it soundly, by growing into the pattern he sees about him.

If he continues sound development, he will assume the same pattern in regard to the community, the local community. He will find his father, mother, relatives, and elders concerned about the conditions in the community. The persons taking responsibility in this field will be people who are admired by his parents, by his elders. He will learn that this is an admirable pattern, this pattern of taking responsibility in things that are needed for the community.

A little later he may develop, if he is soundly developing, a relationship with wider horizons, his State, his province. Eventually, in a few cases (but I think we must face the fact that it is still in only a relatively few cases) we do have people who reach a status of national citizenship. I will remind you, in case you doubt what I am saying, that the status of national citizenship requires an equal degree of loyalty to all the members of the national community, all the members, irrespective of race, religion, or color, or any other group characteristic. Only such people as have attained such status can be regarded as national citizens in the full sense of the term.

Up until quite recently, national citizenship was enough. We have gotten by with national citizenship up until now, but now the world has changed. No longer is national citizenship alone—and that in only a minority of the people—sufficient to preserve the human race in the future.

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For world citizenship

There is an acute and immediate need for world citizens. There is an absolute necessity in the future for people who will assume responsibility for the welfare of the human race, everywhere, not just locally, not just nationally, but for the whole human race.

It is this pattern, if shown to children, toward which they may develop and which it is to be hoped that enough of them may approach soon enough, that is the only hope of survival of the human race for another generation or so.

As the child develops in space he is also developing in the field of time. At first, in infancy, there is no past and no future. There is only now. Soon the child learns a little of the past and a little of the future. He projects himself into tomorrow and the next day. By the time he is 4 or 5 years old he should be able to give up something today to get something better tomorrow or next week. By the time he has reached his early teens, he should be functioning a considerable period ahead of the present. By the time he is in the middle or late teens he should be functioning at least 10 years ahead of the present. He should have a picture of himself in relation to the community. He should have assumed responsibility for what he will be like and what his relationship will be to the community at least 10 years ahead of himself. By the time a person has reached maturity, or that stage of maturity that is appropriate to this degree of evolution of the human race, he should be thinking in terms of at least 2 or 3 generations.

Again, in the past it did not matter if time did not develop much beyond the here-and-now stage. In the future it matters, and it matters enormously. Whatever we do, whatever we say, whatever we expect from our children, whatever we say that may be reported in other countries (and things we say *are* reported in other countries); all people who are truly mature, appropriately mature, to this generation, must consider the effects on the future, not just this year or next, but the far future.

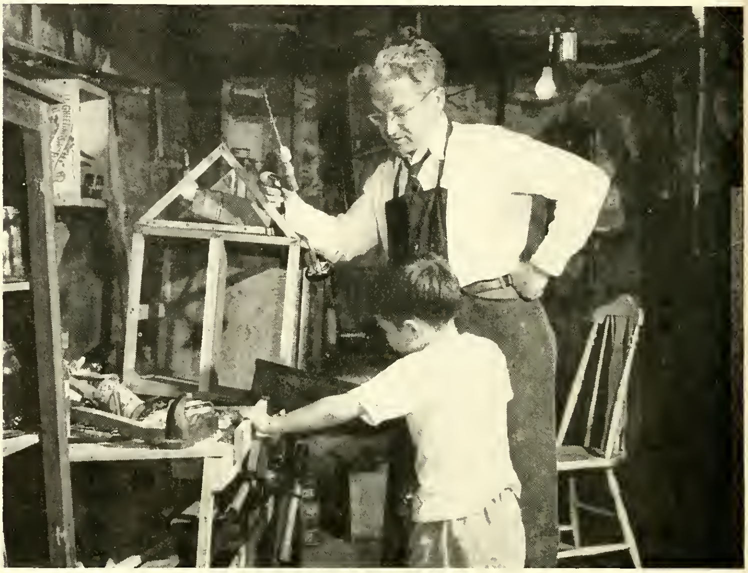
These, for people brought up the way we have been brought up, are difficult concepts. These are extraordinarily difficult goals for us, but we can make them very much easier indeed for our children if we start soon enough, if we catch them young and do not spoil them as most of us have been spoiled.

Particularly, it is highly desirable that the next generation should not be able to fool themselves as casually and as unconsciously and as easily as we have done. They should not be the same kinds of people who can avoid unpleasant things by not looking at them. They should not be brought up, as many of us have been brought up, on a perfectly ghastly symbol that I am afraid many of you have seen in quite civilized homes. The symbol I refer to is three little monkeys, one with his hands over his ears, who will hear nothing distressing, who will hear no evil; another with his hands over his eyes, who will see no evil; another with his hands over his mouth preventing his saying anything about it.

Change symbolism for children

This is the epitome of the laissez-faire attitude most of us were taught. If there is evil we need to see it. Wherever evil lies we need to talk about it. We need to hear about it, and we need to take our responsibility about doing something about it. In this field we need to change our symbolism for our children. It is this teaching of avoiding evil, avoiding seeing or hearing or speaking about it, that has allowed wars to arrive in the past, always to our astonishment, because we did not take responsibility soon enough.

There is a field in which responsibility needs to be shown to children, which in any country, including this one, is rather a delicate matter. It has to do with our social responsibility in relation to social organization. It has to do with our voting, our electing people to positions of responsibility in our governments in every country. Our selection of these people by how we vote puts our lives and the lives of our children in their hands; our human relations as between nations and as between groups of peoples throughout the world are in the hands of the people whom we elect to offices under our governments.


Every child grows into a pattern by identifying himself with a person he admires and loves.

It is very important indeed in the future—it has not been important in the past, or relatively unimportant in the past—that we elect people who are capable of assuming that responsibility and whom we can trust not to allow all our children to die during the next generation.

The requirements are heavy. The responsibility on legislators and on people in government is immense. It is time we began to assume our responsibility in that field and to recognize that human relations throughout the world are the important matters, not our little affairs at home, not our own little comforts or our local peace, not our own ability to make a little more money or to have a bigger and better car, but the feelings of millions of people in other parts of the world about us. These are the important things. These are the things that are going to keep us alive or kill us off within the next few years.

Our upbringing has made it very difficult for us to see these matters. It is important that our children should not be so handicapped. The biggest business in the world, and the most important business in the world, the business which outweighs all other values in the world, is the business of rearing children. This has the greatest importance. The world will be what the children of the next generation make it. It is not just a question of these children being able to live in whatever the world may be like 25 or 30 years from now, but it is a question of what kind of world our children will make, because the time has come when it is essential that man should learn no longer to drift but to take charge of his own destiny as we have not been able to do in our own generation. In order to do this, our children must be freed of many of our taboos, many of our anxieties, and many of our unfounded fears.

They must be free to think in all directions, irrespective of the peculiar ideas of their parents. We must face the fact that we have many peculiarities.

One sees horrible things happen in relation to children now. One sees evidence of parents exposing their superstitions to children who are developing. One sees grown-up people avoiding the number 13 or something of that kind. We see them teaching children that there is no relationship between cause and effect, that the world is full of magics, that there is no possibility of controlling things, except through rituals or weird magics of some kind or another. Our children in the future, if they are to survive at all, must be realists. They must be able to face reality. They must not have available to them the escapes we have had into a fantastic world that does not exist. They must be able to face the reality of their own natures, of their own aggressive drive. They must learn how to cope with these as we have not coped with them effectively.

It is in this mental-health field, to which the 64 nations call attention, and the result in the allied field of social health, that we find the things that need to be done most particularly in the future. For instance, there is no problem in the world in relation to, shall we say, malaria, tuberculosis, venereal-disease control, smallpox, diphtheria, and very many other diseases, except a mental and social problem. All these diseases can be eradicated from the world very quickly if and when we have mental and social health-conscious people. Until we have that, it cannot be done.

I finish by reminding you of our personal responsibility in this regard. This is not a matter for us all in the area of making speeches and writing about it. It is a matter for simple words simply put. It is a matter for personal and individual responsibility in relation to our own children and the children in our immediate vicinity. This responsibility is for every person who is sufficiently emotionally and socially developed to take it up, and it is a responsibility which cannot be avoided.

Reprints available in about 5 weeks.

Federal Agencies Join Hands to Work for Children and Youth

At the suggestion of President Truman, Federal Security Administrator Oscar R. Ewing has invited branches of the Federal Government concerned with the well-being of children and youth to accept membership on an Interdepartmental Committee on Children and Youth.

Among the Federal agencies invited to participate in this Government-wide advisory committee are the Departments of Agriculture, Interior, Justice, and Labor; the Administrative Office of the United States Courts; and the Housing Home Finance Agency. All these agencies have important responsibilities, which, directly or indirectly, affect the well-being of children and youth.

"It is my hope," the President wrote Mr. Ewing, "that the committee will aid in developing appropriate working relationships among Federal agencies concerned and between the Federal Government and State commissions or committees for children and youth, which exist in many States. Furthermore, the committee should assist the various agencies in meeting their responsibilities in this field to the best advantage of the young people of the Nation. It should, of course, recommend methods by which the fulfillment of these responsibilities can be extended and improved."

In releasing the President's letter Mr. Ewing said in part:

"I welcome particularly the importance the President places on the assistance that this committee can give to the Children's Bureau in cooperating with the National Commission on Children and Youth in planning for a midcentury White House Conference on Children. While that event is 2 years ahead of us, a great deal of preparation for it must start now, if it is to be, as it should be, a significant milepost in the people's march toward greater opportunity for our youngsters."

Public Health Service Issues Mental Health Pamphlets

"For Mental Health" is the first in a new series on mental health prepared by the U. S. Public Health Service. It is designed to inform the public about the national mental-health program under the recent National Mental Health Act.

Single copies of the pamphlet may be obtained free of charge by writing to the Chief, Public Inquiries Section, U. S. Public Health Service, Federal Security Agency, Washington 25, D. C. Copies may be purchased in quantity from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 5 cents per single copy or $1.25 per hundred.

Two additional pamphlets, "Training for Mental Health Under the National Mental Health Act," and "The National Mental Health Act and Your Community," are now in preparation.

A TWO-YEAR JOB FOR STATES AND COMMUNITIES

IMMEDIATE, intensive action in all fields pertaining to the welfare of children and youth is urgently needed. In view of this need, the National Commission on Children and Youth, at its January 1948 meeting, recommended that a Midcentury White House Conference on Children and Youth be held in 1950 and that preparatory work, including State and local action, begin at once.

The commission recommended that in each State and Territory the leadership in preparatory work be taken by a group that includes representatives of public and private agencies and citizens' organizations. It suggested that each State committee agree on objectives possible of attainment, in whole or in part, through State-wide effort, before the 1950 conference.

The theme proposed by the commission for the midcentury conference is "The Child in His Family and Community."

As an outgrowth of these recommendations, the Conference on State Planning for Children and Youth met at Washington March 30-April 1, 1948, to initiate State and community action in preparation for the 1950 conference.

The planning conference recognizes that the projected 1950 White House Conference, as proposed by the National Commission, has been established as one geared to action 2 years in advance, a conference springing from grass-roots interest and activities—roots that reach to every State, county, and community, wherever children live.

The commission recognized that the preparatory program will be more fruitful if local communities participate in preconference activities through local counterparts of State committees, with joint planning and action, and sharing of experience.

It has the reinforcement of previous White House Conferences over a period of 40 years, and of the greatly intensified activity in all areas of child services during the depression years and recent war and postwar years.

It also derives strength and resources from the work of the National Commission on Children and Youth and the State youth commissions and committees and the State children's code commissions; as well as from such important conferences related to the welfare of children as the White House Conference on Rural Education (1944), the National Conference on Prevention and Control of Juvenile Delinquency (1946), the National Health Assembly (1948), and the National Conference on Family Life (1948).

Preliminary statement (condensed) of suggestions for State and local action toward a 1950 White House Conference on Children and Youth, developed at the Conference on State Planning for Children and Youth, held at Washington, March 30–April 1, 1948.

Planning for a White House Conference begins against the backdrop of a world in confusion, but searching for ways to reestablish equilibrium. The cause of the world confusion is that people are in confusion.

In achieving essential goals, a total job is to be done: total in its inclusion of all citizens, the organized as well as the unorganized; total in its inclusion of all children—to the ultimate child—in our 45-million child population under 18 years of age.

The beginning of any effective planning is to discover and etch into public consciousness the gaps and gains up to this point.

The well-being of children and youth must be considered, not in mere segments of need, but within the complex of many interweaving social conditions as they affect total development and security. Problems which stem from these conditions are many. To enumerate but a few, there are those relating to economic security of the family; good housing; strengthening the values of home and family life; equal and full opportunities in education for all; improving and expanding the established health and medical services; protection of working children and youth; prevention and treatment of delinquency; and facilities for care of the handicapped.

The National Commission, in its proposals for a 1950 White House Conference, recommended a comprehensive program of research to be developed by a national committee, with cooperation from the States.

The National Commission urges that all at work for children press ahead on already undertaken State efforts and initiate new efforts, so that in 1950 those who meet at the White House Conference not only will take into account what is needed but will have a report on what has been done in the intervening period to improve services for children and youth, and thus have a basis for future action.

In carrying out this assignment by the National Commission the State planning conference demonstrated the way in which representatives of many fields of training can plan together for the good of children. Each person represented a special area of interest, but these interests were fused in a common effort. The work reported upon has come out of community planning, of groups working together, representatives of Federal and State and local agencies, in cooperation with national private agencies and citizen organizations, representing a wide cross section of affiliation.

The programs of action that will be developed in the next 2 years will vary in each State and community in accordance with particular needs and resources. The conference believes that all aspects of planning should be directed, however, toward the single objective of the total well-being of the child.

The Conference on State Planning for Children and Youth accepted the challenge of the National Commission on Children and Youth that work begin now, primarily in States and local communities, in preparation for a midcentury White House Conference.

The conference was organized around methods of achieving action to bring about objectives for the well-being of children.

Discussions by the delegates centered upon: Organization of States and local planning bodies; fact finding; standards and guides needed for State and local action; legislation to achieve action; citizen participation to achieve action: (a) Adult participation, (b) youth participation.

All the group discussions emerged with a few common recommendations, and general agreement upon certain principles of action:

Recommendation that in each State there be established a State-wide council, committee, or commission, representing all agencies and organizations, voluntary and official, which serve children, and also for local planning councils or committees to carry out the same general purposes.

Variations in States and communities in physical, political, economic, and cultural developments require that planning bodies be flexible, to serve each situation. General principles can serve as guides to States and communities, but no one pattern can be set. Purposes of planning should be broad: (1) To reach the needs of all children and youth, and (2) to relate programs and services for children and youth to community responsibility for families and for all people.

The principle of the widest possible citizen participation is endorsed—of partnership between the professional and the volunteer.

The importance of youth participation in community life generally is stressed, and in those fields closely related to activities specially allied to their own interests and welfare.

A first step in sound action by either State or community planning groups is fact finding. A look back to the achievements of the past, with appraisal of what has been done in the various fields of services to children is essential to guide future developments and programs.

Organization of State and local planning bodies

The National Commission on Children and Youth, in proposing that work in preparation for a 1950 White House Conference on Children and Youth begin at once, recommended that planning groups be established in every State and Territory, where such body does not already exist, to work in the interest of children and youth. Such a planning group, whether established specifically for the purposes of strengthening and developing services to and for children, or as an integral part of a general planning body, provides opportunity for citizens to put aims into action. The conference on State planning accepts this recommendation.

The group becomes the tool to get things done.

What the things to be done are grow out of widespread opinion and choice, if the planning group is truly representative and inclusive. Such a group should be, in short, a people's council, never static, but flexible, capable of growth and expansion as the occasion demands, sensitive to changing situations that call for adaptations of organization and goals.

Planning bodies, organized on a broad enough basis to reach the needs of all children and youth, should, within the framework of their wide purposes, have specific objectives related to existing needs and development. Both organization and program should be developed with recognition of the fact that the needs of children and youth are part of the needs of all citizens and cannot be planned for apart from general planning and more widespread action to achieve total well-being.

In initiating planning bodies or making changes in organization in existing planning bodies, States should consider the fact that patterns of organization may be developed under different types of auspices. The three most common auspices are: (1) Legislative authority; (2) Governor's appointment without legislative action; (3) voluntary sponsorship.

Whatever the basis of organization, the composition of the planning body should include established organizations and individuals, assuring representation of all interests and groups. The size of the planning group necessarily will be large in order to include all persons concerned with children and youth in the State and in local communities. Not only wide representation, but continuity of participation is important, with provision for awakening latent interest and extending membership as may be desirable.

The internal organization of each planning group should provide for the most effective use of its membership in achieving the broad purposes and specific objectives. Consideration should be given to executive direction both through a director and an executive committee, with active use of all members through working committees and general meetings of the planning body.

The functions of the planning body will be to carry out the broad purposes and specific objectives. In general, functions may include: (1) Research and fact finding; (2) assessment of facts; (3) clearinghouse for information; (4) interpretation of over-all needs of children and youth and of specific services; (5) programs or action necessary to meet those needs; (6) planning for and promoting legislation; (7) participating in National planning groups and programs for children and youth such as the White House Conference of 1950; (8) coordinating interests, services, and programs for the well-being of children and youth.

Specific programs or methods logically are left to individual planning groups to be developed. It is recommended, however, that any program should be planned on a long-time as well as an immediate basis. An appraisal of the effectiveness of the work of a planning body must take into account the slowness of progress in bringing about more effective use of, or extension of, existing resources for children and youth, and establishment of new programs.

Financial support is essential to maintain the work of any planning group. Methods of securing funds are varied, such as legislative appropriations, grants from foundations or organized financing agencies, and contributions.

In planning and organizing for the well-being of children and youth, techniques and methods will vary greatly, but there are a few basic principles and aims essential to sound planning:

1. Unity of purpose and correlated objectives.

2. Widest possible participation, including governmental agencies, civic groups, youth groups, church, labor, legislative representation.

3. Working through established organizations but leaving the door open to individually interested citizens.

4. Provision for wakening latent interest.

5. Keeping in mind in all planning the relation of the child to the family, and that the cornerstone of the well-being of children and youth is wholesome family life.

It is recommended that:

One of the following methods be used in every State and Territory for commissions on children and youth: Sponsored by State-wide voluntary organizations; appointment by Governor; passage of enabling legislation to set up organization.

State and local planning bodies adopt the suggestions of the National Commission on Children and Youth, on action by States and communities, as follows:

1. Review and evaluate resources under public and private auspices available within the State or Nation that affect families with children, noting gaps in extent and content of services.

2. Secure and make use of information from Federal and other national professional and lay agencies and evaluation of new programs, organizations, techniques, and methods of operation that can be used in developing activities and programs.

3. Agree on some specific objectives they want to achieve for the children in their own communities and States.

4. Work toward the achievement of these objectives against the deadline of the 1950 White House Conference.

All Federal agencies with any interest in children and youth coordinate their planning activities with particular reference to field consultation with State and local committees, and as nearly as possible also clear the information and suggestions which flow from Federal to State and local agencies. This coordinated planning should begin now and be as widely inclusive as possible. Federal and national agencies should encourage the formation of State and local planning bodies and should assist them in their programs.

Fact finding

Two kinds of fact gathering should be considered in connection with the 1950 White House Conference: Scientific, expert research and the collection of community data by citizen groups. Both are important in the over-all situation. The latter type of information, usually assembled by unofficial groups, would point up the problems requiring research. Research experts in State and national agencies would then prepare material which would be used as study guides by lay groups, to be interpreted and implemented in the light of their own local situations.

In a search for facts pertaining to children, supervision should be in the hands of a professional research staff rather than of isolated groups working in various fields.

Specifics instead of general goals should be the aim in fact finding so that the goals may be more possible of achievement. Also, specific guides are needed in order to provide yardsticks.

It is recommended that fact finding be a fundamental function of a State-wide council, committee, or commission of official and voluntary organizations and agencies that serves children. These functions are defined in "State and Community Planning for Children and Youth," Children's Bureau Publication 312 (p. 7) as:

"Successful planning in any field involves collection and interpretation of facts concerning needs to be met, services available, and the utilization of these services by those for whom they are designed. This requires adequate research. Such research should be carried on, whenever possible, by the departments or agencies of the State government responsible for providing services in the fields of health, education, social welfare, employment, and related services. It should be the responsibility of the council on children and youth to utilize and correlate results of such research done by these and other agencies,

These earnest young people, with an adult consultant, are discussing a community project.

both public and private; to encourage and promote the development of adequate research programs as an essential part of the work of these agencies; and to conduct such fact-finding activities of its own as may be necessary to supplement the information otherwise available."

Insofar as possible, personnel connected with studies of child health and welfare should be related to the State planning group.

It is recommended that the State chairman or a representative as designated by the Chairman of the American Academy of Pediatrics be a member of this State-wide group in order that the Academy's recent Study of Child Health Services be interpreted and used as widely as possible.

In order to help the States give guidance to local community groups it is urged that a research committee of the National Commission on Children and Youth, as proposed in the January 28–30 suggestions, be set up at once and that it disseminate information to the States as soon as possible.

It is recommended that data be organized so that it always relates to the child as a whole. This means that there should be some technique of clearing information between different professional and lay groups as well as between geographical units.

It is recommended that immediate emphasis be placed on the *utilization of services* as well as adequacy and availability of those services.

Each State should study its needs and put on at least one research demonstration which would put into effect the integration of various professional skills in the interest of the child in the family and community before the 1950 White House Conference.

It is suggested that the Federal Government conduct the research in certain areas where direct action for solution of a problem may be needed at the Federal level—where State action alone would not be effective, as in matters involving international migration, interstate migration, and adoptions involving placements across interstate or international boundaries and in this instance within States and on a Nation-wide basis.

Standards and guides needed for State and local action

In formulating principles and methods to be applied to the well-being of children and youth, it is well first to define a standard. (A standard is that which is set up and established by authority, custom, or general consent, as a model or example; criterion; test.)

It is agreed that "standard" applies to a wide range of concepts, from goals to rules and regulations. Standards serve to bring unity, stability, continuity, guidance, quality, evaluation, adequacy, and equity to any program.

1. Standards can be made and kept truly alive only if representatives of all related or allied professional agencies, as well as community groups and individuals, participate in evolving such standards.

2. Essential steps in developing standards through local acceptance and participation are: (a) Recognizing the problem and understanding the need (education); (b) assessing all the resources available or obtainable; (c) seeking outside guidance and assistance; (d) keeping the standards dynamic and flexible; (e) activating the standards through coordinating efforts of groups and agencies; (f) providing for specially trained personnel to promote public understanding of the problem and action to be taken.

In preparation for the 1950 White House Conference the representatives of each State should review existing standards, particularly those set up in various fields by previous White House Conferences, to see: (a) Whether they are now considered appropriate; (b) how much progress has really been made in accepting and using them at the State and local levels.

In line with the above the Children's Bureau should formulate a simple statement of the broad goals set out in the General Report of the White House Conference on Children in a Democracy (1940), appropriate for wide distribution.

Legislation to achieve action

Principles that should underlie the selection of legislative objectives for children and youth to be sought prior to 1950 are:

a. Legislation should provide authorization for services that contribute to the well-being of all children in such fields as public welfare, health, education, recreation, labor, and related fields, as well as services for children with special needs.

b. Authorization for services should be in comprehensive terms so as to permit the development of broad and flexible programs.

c. Provision should be made for constructive measures that will prevent the development of conditions harmful to children and youth, as well as for corrective measures needed to deal with such conditions.

To select legislative objectives to be sought, each State will need:

1. To secure information about (a) existing State laws and services affecting children and families and (b) standards available for evaluating existing laws and drafting new measures.

2. To obtain facts as a basis for judging to what extent a standard in a given field is applicable to the needs of children within the particular State.

3. To decide upon legislative proposals to be included in the immediate program and long-range legislative objectives.

4. To make full use of existing agencies and channels in planning for new and expanded services.

5. To consider legislation that will promote the development of cooperation and reciprocal agreements between States in services for children (with special reference to nonresidents).

It is recognized that *preparation for legislation* requires consultation between administrative officials and citizens' groups on needs to be met, as to whether legislation is the best means of attaining the ends sought, and on the type of measure that will be effective. *Drafting bills* requires technical service from experienced legal draftsmen. *Presentation to the legislature* should include enlisting the understanding and leadership of committee chairmen and other legislators in both houses and the active discussion and support of *citizens* in communities throughout the State.

In formulating its own legislative program, each State needs information about the laws of other States affecting children and youth and standards developed on the basis of Nation-wide experience. It was recommended that the Children's Bureau have research personnel available to supply the States with:

(a) Information on existing State laws relating to children and the family.

(b) Standards to be used in reviewing the laws in each State and in preparing new legislation.

(c) Review service on bills being drafted for State legislative consideration.

Citizen participation to achieve action

Bringing many citizens into State planning, either as individuals or as members of organizations, though at times it may slow up the turning of the wheels of organization, has values that far outweigh the odds involved. All possible volunteer citizen organizations should be brought into State programs for children and youth.

Participation of citizens should be planned, coordinated, and active, not of an onlooker, receptive nature.

In local planning there is danger of rural areas' falling through the organizational sieve. Encouragement to rural people to develop their own leadership is advisable.

The problem of bringing in the inarticulate, unaffiliated minority groups presents a challenge. Various channels through which to reach these groups are suggested: The schools; neighborhood community councils; clubs; libraries; the block system of house-to-house approach used during the war. One of the surest ways to reach parents is through their children.

As one method of stimulating citizen participation in children's problems, governmental agencies may utilize organized instruments. In other words, governmental agencies themselves have responsibility in citizen participation. In particular, this responsibility includes making available information and resource material in this field for the use of citizen groups.

Such States fortunate enough to have both volunteer citizen organizations, such as citizen councils on children, and official, statutory children's commissions, should hesitate before merging the unofficial body with the official body. Some functions, it is suggested, might remain for the unofficial groups and each State should give serious consideration to these functions before reaching a decision to merge or abandon them.

Before criticizing or opposing governmental bodies, citizens should first go to them with a request for their cooperation—a further invitation to citizen participation.

There is a place for the lay volunteer and for the trained person in children's and youth programs, and in the local communities, particularly, local conditions may determine that place. It is concluded that the local community can best be served by the "general practitioner" or all-around type of trained person rather than one highly specialized, who has a more appropriate place in metropolitan areas.

Professional groups are in the best position to lay down principles for good action for the guidance of citizen groups, and such principles should be unified and adapted to practical application in matters affecting children.

Surveys are a good way of arriving at citizen understanding of local problems, and, with certain reservations, provide a means of inviting citizen participation.

A sound program of public relations is essential in stimulating citizen participation.

Youth participation is a gradual process beginning with the preschool child in the family, and continuing through all relationships in the classroom and on the playground, with the gradual assuming of more responsibility in elementary and secondary school years.

Adults should make provision for the various kinds of experiences which prepare youth to participate adequately in affairs which concern them:

A child needs to understand that participation involves responsibility in accordance with his age and experience.

There must be recognition of a child's needs and rights in play and leisure-time experiences and in work, school, and other areas.

Education for home and family living must be provided in school.

Provision for services such as are provided in some guidance clinics should be made available for more children and youth, including services of psychiatrists, psychologists, social workers, and psychiatric social workers.

Many adults will need experience and education which will prepare them to participate understandingly with youth.

The following are suggested:

Agencies such as the Office of Education and the Children's Bureau to promote the making of movies that will provide education without seeming to teach.

Radio to be utilized as a means of family participation.

More informal groups for parent education to demonstrate the nonauthoritarian fashion of discussion.

Parent education through the technique used in connection with nursery school and kindergarten to be given.

Opportunity to be provided for parents to have classes and informal education based on their interests in this area.

Teacher education to emphasize child growth and development, including teacher-pupil planning, recognition of the ability of youth to contribute to planning.

It is recommended: That youth participate in a planning body on a State basis inclusive of governmental agencies and voluntary organizations concerned with planning regarding children and youth, sponsored either by governmental organizations or voluntary organizations or by a combination of both.

That youth have a major role in community activities in which they have interest and experience and in which the chief roles are usually played by adults. Such activities include: Recreation; health; education, including citizenship; youth employment; various community services, such as surveys of community needs, safety, and opinion-poll studies.

That communities might consider the establishment of interorganizational youth councils, composed of young people elected by youth organizations, schools, churches, and so forth. The purpose of these councils would be to work with adult consultants in developing community projects on which adults and youth can unite their efforts. This experience would offer opportunity for youth to learn to represent others, give experience in dealing with community problems, and provide a spokesman group for the young people themselves.

That the Youth Division of the Na-

(Continued on page 190)

COMMITTEE REPORTS ON CARE FOR CONVALESCENT CHILDREN

ALL children at some time experience illness, but most of them return to health after a brief and uneventful convalescence. For thousands of children, however, recovery is a long-drawn-out process. These children generally benefit from supervised long-term care, which is generally called convalescent care. Such care is for the most part a modification of the plan of care and treatment given the child during his acute illness.

Convalescent care is usually planned in relation to a single illness. There are, however, children with chronic disabling conditions who respond to therapy after episodes of their disease. For such children, convalescent care must be planned periodically in order that they may, between illnesses, live a relatively normal life.

Any plan of convalescent care for the individual child must take into consideration the child's physical, mental, and social needs, if such a plan of care and management is to attain its full objectives.

Continuing medical care and other convalescent services may be offered to children in one of three environments: At home, in a foster home, or in a special institution or convalescent home.

Each of these environments has its special virtue for the individual child and should be used as a convalescent resource only after careful study of the medical and social needs of each child.

The convalescent plan should be developed by a team of professional workers skilled in evaluating the convalescent needs of children and in relating available convalescent resources to these needs. Such a team will ordinarily include the physician, the nurse, and the medical social worker.

The physician, who should be one trained and experienced in the care and management of children, should be in attendance at sufficient intervals to ensure good medical supervision. He may wish to consult the various medical specialists as occasion demands.

Besides the physician, nurse, and medical social workers, the child may need the services of other workers, such as nutritionists, teachers, and occupational and play therapists. It will be necessary to balance these services in order to gain for the child a satisfactory social adjustment and optimum physical gains during the convalescent period. Adolescent children with residual crippling receive additional help at this time if some analysis of their vocational interests is made and vocational guidance is offered to them.

One activity that convalescent homes for children consistently provide for is school instruction.

Whatever measures are necessary to help the child's recovery, convalescent care, to be successful, must be directed to the needs of the whole child. Not only must attention be given to every physiological factor that affects his growth and development, but he himself must be considered as a living, changing person, whose mind and body jointly share in his recovery and in the process of his growth.

Little has been known so far about the convalescent facilities and services for children available in the United States as a whole. The nearest approach to such knowledge is the directory compiled in 1942 by the National Society for Crippled Children and Adults.

In May 1944 the National Society initiated a country-wide study of convalescent care for children. This study was conducted by a committee representing the basic professional fields that serve children during convalescence.

The objectives of this study as set forth by the committee were: "To explore the physical, mental, and social needs of children during the convalescent period; to define the optimum standards which should govern the provisions for care; and to determine the needs for the extension and improvement of convalescent facilities for the physically handicapped child in this country."

Questions for which the committee sought answers were: (1) What facilities and services are available to assist children recovering from illness toward establishment of optimum health? (2) How can adequate convalescent measures be made available for all children recovering from illness?

The committee sought information from several sources, as follows:

To get an indication of the needs of individual children for care during convalescence, the committee requested nine

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Excerpted from "Convalescent Care for Children," the report of a study authorized by the National Society for Crippled Children and Adults, and made by a committee including A. L. Van Horn, M. D., chairman; Edith M. Baker; Jewell Gaffney, R. N.; Harry H. Howett; Isabelle M. Jordan, R. N.; Elise H. Martens; Waldo E. Nelson, M. D.; and Allen F. Voshell, M. D. Kathleen Allen was director of the study.

hospitals serving children to state what recommendations they had made for each child discharged during a 31-day period. These hospitals were located in six cities: Seattle, Chicago, Louisville, New Orleans, Philadelphia, and Washington.

An increasing number of cities throughout the United States have a clearing unit for health and welfare agencies, called the council of social agencies. For judgment of the needs of city children for convalescent care, the committee turned to these councils. The councils were asked: (1) What convalescent services were available in their community? (2) What services needed to be supplied? (3) What, in the council's opinion, would be an adequate program for children in that community? Of 240 councils approached, only 61 furnished information. These 61 represented cities with 23 percent of the population of the United States.

The largest purchasers of convalescent care for children are the official State agencies that administer services for crippled children. Since these services are largely given in rural regions, the committee asked for information about convalescent care given to rural children and also about the children unable to get such care. Thirty-eight States reported this information.

State crippled children's societies were also asked for opinions concerning the problems of convalescent care for children in their respective States. Twenty-five States were represented in these answers.

The committee invited all the hundred-odd convalescent homes for children known to be operating in the United States to participate in the study. Three-quarters of these homes, located in 31 States in all regions of the country, cooperated by giving complete information on all phases of their operation. The information was provided through questionnaires and through personal interviews between the director of the study and the staffs of the homes. The data collected from these homes should be helpful to organizations planning to establish new convalescent homes or to improve the services given to children by homes already operating.

The discussions of the committee on convalescent care for children have been focused on the needs of children during the convalescent period, the adequacy of existing facilities and service for meeting these needs and the definition of principles which should be considered in future planning in the field. Certain conclusions of the committee follow:

A child in a good convalescent home is occupied with the normal activities of his age group.

What was learned from the study

Relatively little information is available based on scientific studies in regard to the physiological and emotional aspects of convalescent care for children.

Convalescent services and facilities are provided for only a small fraction of children in the United States who need such care. Where convalescent services and facilities have been developed for some children, coverage is not in any instance sufficient for all diagnostic age or racial groups which may need convalescent care in any one community or State.

No instance was discovered by the study committee where State-wide or community-wide planning for the development of adequate convalescent services and facilities for children was under way.

Needs of the convalescent child were considered by only a few communities; these have developed programs to meet these needs. The selection of a convalescent facility for the child is not always made on the basis of his need, but is more often determined by the facility that is quickly available.

Children often travel long distances and remain away from their homes for long periods to obtain convalescent care not available near their homes.

Children also frequently remain in hospitals long beyond the time when they are ready for discharge, or they return to homes where convalescent regimens cannot be maintained for them, because no convalescent facilities appropriate to their needs have been provided.

Children's convalescent homes in general are not affiliated with medical centers or hospitals. This leads to isolated administrative policies which may be at variance with the best interest of the individual home.

The administration of convalescent homes has not been given serious consideration by professional and standardizing organizations concerned with the administration of other health and medical facilities.

Convalescent homes for children are rarely subject to effective licensing regulations under health or welfare authorities.

No curriculums for the training of administrators or personnel in convalescent homes have been established in relation to schools of hospital administration or other appropriate educational programs. Conversely, convalescent homes do not as a rule offer staff training programs for student groups from related professional fields.

There is no uniformity of personnel requirements among convalescent homes for children.

Needs of children which relate to growth, development, and mental health are not universally recognized by personnel who deal with children in convalescent homes.

Although all convalescent homes for children maintain school and activity programs, such programs are not always in keeping with progressive methods of modern education.

A minority of homes make allowance for the staff to live outside the home.

Foster homes for the placement of convalescent children who particularly need this type of care have not been developed in many areas of the country, although many child-welfare agencies accept an occasional convalescent child for care.

Child-care agencies that specialize in foster-home placement of convalescent children are currently hampered in their objective through inability to obtain enough foster homes. Convalescent services are not available in many parts of the country to children who convalesce in their own homes.

Where nursing and other recovery services are available in the child's community, they are not always coordinated to his best advantage.

Home teachers for convalescent children are provided by boards of education in some urban communities but for the most part are unavailable to rural areas.

Housekeeping aides to assist the family during the child's convalescent period are now provided by a negligible number of urban communities.

Convalescent homes seldom have medical social workers as staff members.

What the committee recommends

The Committee on Convalescent Care for Children recommends:

1. That councils of social agencies and other community organization groups emphasize the needs of convalescent children along with planning for all other children within their community.

2. That area studies be made of the needs of convalescent children to determine what groups of sick children lack convalescent care and to what extent the community should establish provisions for such care.

3. That standard-setting groups in the medical care and hospital fields include in their deliberations the problem of the convalescent child, to the end that sections on convalescent care for children be set up within these groups.

4. That curriculums for the training of personnel to serve in convalescent homes be established at appropriate educational centers throughout the country.

5. That the importance of the convalescent period of illness be emphasized in the teaching of medical students and students in the basic fields which serve convalescent children.

6. That convalescent needs of children in any one community be considered in relation to the need of the child and that facilities be developed to meet need in all diagnostic groups without limitation because of age, race, or religion.

Should affiliate with hospitals

7. That convalescent homes which serve children affiliate themselves with children's hospitals or general hospitals, which preferably in turn are associated with medical schools and with teaching programs in the allied professional fields.

8. That convalescent homes for children integrate themselves more widely with other community endeavors and citizen groups.

9. That the building of convalescent homes not only provide for the medical services necessary during the convalescent period but for the educational and recreational needs of the children who will receive care in the individual institution.

10. That although it is recognized that adequate grounds are necessary, the convalescent home be placed near enough to the affiliated hospital to allow easy access to it by all supervising professional groups.

11. That convalescent homes for children seek to establish themselves on a broader financial basis, in order to establish more adequate treatment programs for children under care. As a means to more effective financing, it is recommended that convalescent homes develop sound cost accounting practice.

12. That the program in children's convalescent homes be geared to the current thinking in regard to the medical, social, and mental hygiene needs of the convalescent children.

13. That all convalescent homes for children recognize the need of the professional staff for progressive development through the allowance of educational leaves and attendance at professional conferences, and that for all personnel there be staff-development programs, not only in their specific fields but in the general areas of child care and development.

14. That boards of convalescent homes recognize the desirability of staff members' living away from the home, with the appropriate financial compensation and alternate help to allow for such arrangements.

15. That more units for the foster-home placement of convalescent children be developed under child-welfare agencies in both urban and rural ares.

16. That such foster-home units for convalescent children include in their program: Research as to number of convalescent children appropriate to a foster family, cost of maintenance of convalescent child to the foster family, and methods of supervision of the convalescent child in the foster home in nutrition, education, recreation, and mental hygiene.

17. That more convalescent services be made available to children who convalesce at home, that is, public-health nursing, physical therapy, medical social service, nutrition, occupational and play therapy, housekeeping-aide service.

18. That communities correlate and give appropriate emphasis to recovery services offered to the convalescent child at home.

19. That State and National legislation, which provides for the education of exceptional children, including children convalescing in their own homes or in foster homes, receive support from all individuals and groups interested in convalescent children.

20. That individuals and groups interested in the health of children throughout the country support effective voluntary and governmental measures which provide medical care for sick children, including children during the convalescent period of illness.

Reprints available in about 5 weeks.

A Two-Year Job for States and Communities

(Continued from page 186)

tional Social Welfare Assembly be requested to assemble stories illustrating youth participation at the various age levels to be used as a working tool.

That adults who deal with children and youth in institutions, including correctional and other institutions for children away from their homes, be better qualified to carry out youth-adult planning in the institutional program.

That children and youth with handicaps have opportunity for participation to the limit of their capacity in regular community groups with other children and youth.

That broader and richer experiences be provided for all children in order that they may grow into more mature, self-disciplined participating citizens in a democracy. This experience should be provided in schools and in other settings in which children and youth are, including family and neighborhood groups, youth-serving organizations, churches, and so forth.

For immediate citizen action, it is recommended:

That the Children's Bureau, or other Federal agency, collect as a central reference source, the questionnaires and survey material many groups have used to study problems in their own communities and States. The purpose of this collection is to avoid duplication and waste of time for other communities wanting to start on the road to social action by way of self-study of their own conditions.

That national organizations prepare high-quality professional radio programs that can be used in communities for a sound public-relations program, and in addition that universities be encouraged to hold workshops on radio-program preparation so that we can be trained to make effective use of local radio outlets. The purpose of this is to improve the quality of radio-program material relating to children and youth.

That each and every citizen organization regard as an outstanding challenge the individual citizen who is not affiliated with any organization, to bring him into full participation not only as a citizen but as one concerned with these child problems which we all face.

● IN THE NEWS

National Health Assembly Meets May 1–4

As we go to press the National Health Assembly, composed of more than 800 persons concerned with various phases of the Nation's health, is meeting in Washington.

The assembly has been called by Oscar R. Ewing, Federal Security Administrator, at the request of the President of the United States.

The President's Child Health Day Proclamation, published in this issue of *The Child*, is being followed through by the maternal and child-health section of the assembly.

For Work With Blind Children

Delta Gamma Fraternity has a $1,000 annual fund, from which scholarship awards are available for preparation of persons intending to become: (1) Orthoptic technicians, (2) teachers of partially seeing children, or (3) specialists in work for blind preschool children. Anyone wishing to specialize in one of these fields may be eligible for assistance, the amount in each case to be determined by the particular need and costs involved. If you want to enroll for training in one of these fields, apply for a scholarship to Mrs. Richard P. Miller, 39 West Jefferson Road, Pittsford, N. Y.

Summer Courses

Institute of Child Welfare, University of Minnesota, Minneapolis 14, has a threefold program, which includes research in child development, the training of teachers, and State-wide services in the fields of parent education, family life, and child guidance. First term, June 14 to July 23; second term, July 26 to August 27.

Louisiana State University School of Social Welfare, Baton Rouge 3, is offering 3-week courses on services for children in foster care; supervision in social case work; trends in child welfare, public welfare, and social case work (June 4–25); and a 3-week workshop in social treatment of offenders (July 19–August 6).

Among the subjects of 9-week courses are: Juvenile delinquency, social services to children, and visiting teacher work (June 4–August 6).

Mills College, Oakland 13, Calif., offers a summer-session program in child development which will emphasize early childhood education, with opportunities for directed teaching in the nursery school, open to qualified students. General courses will cover all aspects of growth and development, physical growth, child psychology, family behavior, and child personality. The program is open to professional people as well as parents and other laymen (July 3 to August 14).

New York School of Social Work, Columbia University, New York 10, will hold three series of summer institutes for experienced social workers. Series I, June 21–July 2; Series II, July 12–23; Series III, July 26–August 6.

School of Social Work, University of Denver, Denver 10, Colo., provides graduate professional education in five specialties: Family case work, child welfare, social group work, psychiatric social work, and administration. Registration for summer quarter, 1948, June 18–19.

● CALENDAR

May 24–29—General Federation of Women's Clubs. Annual convention. Portland, Oreg.

May 23–28—American Physiotherapy Association. Twenty-fifth annual meeting. Chicago, Ill.

May 24–26—National Congress of Parents and Teachers. Cleveland, Ohio.

May 31–June 4—National Organization for Public Health Nursing. Biennial nursing convention. Chicago, Ill.

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FOR YOUR BOOKSHELF

THE GROUP LIVING OF CHILDREN. Citizens' Committee on Children of New York City, Inc. 136 East Fifty-seventh Street, New York 22, N. Y. 1948. 25 pp.

"It is now generally accepted," says this excellent booklet, "that a certain amount of daytime group living away from home is beneficial even to the very young child, and that the needs of family and child demand planning for such opportunities on a permanent basis."

"Too often," the report goes on, "nursery schools, kindergartens, day-care centers, play schools, and after-school centers are still run on the simple, antiquated concept of 'keeping children off the street,' while they pay little attention to the needs of a growing and developing child, or to the standards of care. Moreover, many new facilities have been opened up haphazardly, without satisfactory facilities, constructive programs, adequate standards, or responsible supervision."

To help those who are eager to create new services or improve existing ones, the Citizens' Committee on Children has issued this simple statement of the needs of the child at different age levels and of the factors that contribute to good programs for children.

Having learned from experience that a child under 2 is not ready for the big step of entering group living away from home, the committee recommends that these little children should not be enrolled in a group. For children past 2 it suggests how the child can be helped to take his place in the group, how he can be eased into the new experience without the shock of too sudden change from home life. After discussing the human atmosphere of children's group life the pamphlet goes on to such tangibles as administration and operation, facilities, staffing, and program.

The section on the school-age child—6 to 13— was largely contributed by the Play Schools Association. "We must insist," this section says, "that the responsibility of the school to its children and to the community it serves does not end at 3 p. m. and that extended services, depending on needs, be established to enrich and reinforce school programs."

A comprehensive list is given of play equipment and other equipment, both indoor and outdoor, for children of preschool age, of those 6 to 8 years, and of those 9 to 12.

I. Evelyn Smith

A MESSAGE TO PARENTS, 1948. National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y. Publication No. 51. March 1948. 6 pp.

The National Foundation is for the second year distributing a folder of information on infantile paralysis to pupils in public, private, and parochial schools.

Infantile paralysis, says this little folder, does not break out often, but when it comes, it is important to know what it is, what to do about it, and where to turn for help. The disease attacks few people, the folder continues; 20 cases per 100,000 population usually is considered an epidemic. Half of all those who get the disease recover without crippling. Another fourth, with good care, recover with slight permanent crippling. Deformities may be prevented and crippling lessened by prompt, complete, and sometimes prolonged medical care.

The folder lists precautions to be taken if infantile paralysis comes to a community and tells what the National Foundation will do to help patients.

BABY'S DAILY TIME CARDS. Federal Security Agency, Social Security Administration, Children's Bureau. Washington. Revised 1947. 10 pp. Single copies free.

For a mother wanting a guide in planning her day-by-day care of her baby, this set of five cards, planned to be hung on the wall, can be an ever-present help.

One card gives pointers on taking care of the baby during his first 4 months. The others do the same for various ages up to a year.

The front of each card gives a suggested daily schedule, with hints on feeding, sleep, and play. The back of the card discusses foods and other things referred to on the front. The schedules are only suggested; they are not necessarily the best for all babies, nor the most convenient for their mothers. Spaces are provided on each card so that every mother can write in the time she finds best for the baby's bath, or for any other item in his schedule. She can also change her plan from time to time, to meet the changing needs of her baby.

The cards make it clear that the mother should not worry if something upsets her plan now and then—that there is nothing sacred about a schedule.

Panel Reports of Delinquency Conference Now Available

The panel reports of the National Conference on Prevention and Control of Juvenile Delinquency, which was held at Washington, November 1946, heretofore available only in mimeographed form, in limited quantities, have now been printed. They are for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

The reports can be bought individually or as a group of 18. Special rates are provided for quantity orders of any report. The prices of single copies are as follows:

No. 1, Community Coordination, 15 cents; No. 2, General Recommendations for State and Community Action, 10 cents: No. 3, Juvenile Court Laws, 15 cents; No. 4, Juvenile Court Administration, 10 cents; No. 5, Juvenile Detention, 15 cents; No. 6, Institutional Treatment of Delinquent Juveniles, 20 cents; No. 7, Role of Police, 15 cents; No. 8, Housing and Juvenile Delinquency, 15 cents; No. 9, Recreation for Youth, 25 cents; No. 10, Mental Health and Child Guidance Clinics, 10 cents; No. 11, Youth Participation, 10 cents; No. 12, Citizen Participation, 15 cents; No. 13, Case Work-Group Work, 15 cents; No. 14, Church Responsibilities, 15 cents; No. 15, School and Teacher Responsibilities, 15 cents; No. 16, Home Responsibility, 15 cents; No. 17, Rural Aspects, 25 cents; No. 18, Statistics, 15 cents.

THE ROAD TO GOOD NUTRITION, by Lydia J. Roberts in collaboration with members of the Children's Bureau staff. Federal Security Agency, Social Security Administration, U. S. Children's Bureau Publication 270. Washington. Revised 1947. 51 pp. Single copies free.

This is a second revision of a bulletin first issued in 1942. It is intended to enable persons responsible for the health of children to become better acquainted with the child's nutritional needs at various stages of life and with methods of dealing with such needs.

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"May Day has a long and pleasant tradition among all English-speaking children. It might well be chosen by their elders as a day which should be not only a festival but also year by year a celebration of some increase in the common store of practical wisdom with which the young life of the Nation is guarded by each community."

Julia C. Lathrop, 1916.

CHILD HEALTH DAY, 1948

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A Proclamation

WHEREAS the Congress, by a joint resolution of May 18, 1928 (45 Stat. 617), authorized and requested the President to issue annually a proclamation setting apart May 1 as Child Health Day; and

WHEREAS the potential strength and future greatness of this Nation depend in large measure upon its children; and

WHEREAS the protection of the health of young Americans will help to assure the continued physical welfare of our people:

NOW, THEREFORE, I, HARRY S. TRUMAN, President of the United States of America, do hereby designate May 1, 1948, as Child Health Day; and I invite all parents, doctors, nurses, teachers, and all others who are interested in child welfare to cooperate in a Nation-wide effort, beginning on that day, to improve the health of children of school age.

I recommend as a first step that practical plans be developed to obtain thorough medical and dental examinations and treatment if necessary for every child entering school for the first time in the fall of 1948, to the end that all correctible defects found in the health of these children shall have been removed or placed under treatment by the close of the school year.

In order to give impetus to this effort, I request the National Health Assembly, meeting by invitation of the Federal Security Administrator in Washington from May 1 to 4, to give special consideration to the health needs of children of school age.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this sixteenth day of April in the year of our Lord nineteen hundred and forty-eight, and of the Independence of the United States of America the one hundred and seventy-second.

Harry Truman

By the President:

Robert Lovett

Acting Secretary of State.

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CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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the CHILD

County boards and child-welfare services

OF DOCUMENTS
AUG 24 1948

LYDIA H. CAGE

Community Planning Consultant, Division of Child Welfare, Texas State Department of Public Welfare

IN TEXAS the State program of child-welfare services is carried out in some counties by a child-welfare board appointed by a county commissioners court, instead of by a county department of welfare, as is usual in most of the States.

One of the ways in which Texas seeks to strengthen and extend services for children is to develop, in certain counties, a cooperative program between the State and the county. These county boards cooperate financially with the State agency in order to strengthen and extend services to children in their county. Texas has no foster-care funds available from the State general fund, and so all of the funds for foster care are supplied locally, while the State pays fully or in part the salaries of professionally trained child-welfare case workers. The public child-welfare program so carried on is county-wide and serves children irrespective of their race or economic need.

Joint State-county administration

These agencies are called county child-welfare units, and they carry the names of their respective counties. Each unit has a child-welfare board. The State division of child welfare assumes technical supervision of these units, and jointly with the local child-welfare board administers the program of child welfare in that county.

The board has certain general legal authority in child-welfare matters. Although the act creating the State department of public welfare provides that the commissioners court *may* appoint such a board, the policy of the State department makes it a *requirement* that the county appoint the board before a child-welfare unit is organized within its boundaries.

The board consists of seven men and women. It adopts its own by-laws and discharges its functions as the community's representative in matters of child welfare, not only directing the child-welfare unit but assuming leadership in the promotion of all areas of the welfare of children.

An instance of this in a mid-State county was evident when the county child-welfare board became interested in visual education. On looking into the local school system the board had found that visual education was not included. The pros and cons of this came up for discussion at several monthly board meetings. Finally the board appointed a committee of its members to visit the nearest school system that had visual education, to study it, and to see how it worked out from the viewpoint of teachers, patrons, and pupils. The committee returned a favorable report to the board.

The next step was to acquaint the local school superintendent with the committee's findings. When he was converted to the point of presenting the subject to the school board and interpreting to the community the advisability of including visual education in the school program, the child-welfare board's committee disbanded and the board officially withdrew, as its purpose had been accomplished. Its part was to get behind a project which would benefit all children in the community and to push it to the point where it was launched by the proper agency, under whose administration it should fall.

Another county child-welfare board disapproved of the child-labor practices in the county. As a board appointed by the commissioners court, the county board protested against the current situation to the county judge of that court. The result was disappointing, as the child-labor laws of Texas did not cover the situation, but the board had at least registered its disapproval in the matter.

Interpretation is the bright strand weaving through the activities of a county child-welfare board. A community cannot believe in a program it does not understand; hence continuous interpretation of the program, formally and informally, is necessary. Interpretation of the progress of the program as it develops is essential; to do this the board must be an informed board and must keep abreast of the program.

To keep her board informed of the problems which especially have community significance is one of the big responsibilities of the county child-welfare supervisor. This takes time but it earns dividends. In a contested custody case the entire seven members of a county child-welfare board spent the whole day in the district courtroom. They were busy men and women; several of the men were officials in commercial companies, yet they were interested enough in the welfare of a so-called underprivileged child to give their valuable time to support the program and show the community they were on the job.

Board represents community

This need for interpretation is twofold. The board knows the community and its lares and penates; and, more important still, the board knows the tempo of the community. If a child-welfare staff is to work successfully in a community all its members must be aware of these things and adjust accordingly. What the board knows, and the board's attitude on these situations, are of inestimable value to the workers.

We find board members asking for literature—articles and pamphlets—on various phases of the program, so that they may better discharge their responsibilities.

The commissioners courts have taken the appointment of these boards very seriously. Invariably strong persons have predominated on each board appointed. Perhaps the greatest responsibility falls on the members of the original board (all boards rotate) as they pioneer on the social-welfare program of the community as leaders in the field of child welfare.

It has been previously stated that all funds for the actual care of a child have to be raised locally. As the program grows there is of course an increased case load and an increasing cost for maintaining children. Thus the board has another continuous responsibility—that of fund-raising. Even though annual budgets are planned, and funds raised, additional resources are always needed.

Resources such as services from doctors, lawyers, and so forth, as well as cash for extracurricular activities, and donations in kind, such as Easter outfits, costumes for school and community activities, are required constantly by the workers in planning with the children. These resources are made available through efforts of the board members.

The bulk of the work of the board is done through committees. These are organized and appointments made as the need for them arises. Each is headed by a board member, with nonmembers making up the main body of the committee. The number of members varies with the nature of the committee. The following committees have been found to be expedient.

The case committee is one of the most important. Its services are specialized, as the committee works closely with the child-welfare workers and, with their guidance, discusses problem cases. Here is an excellent chance for the committee, knowing the prejudices and traditions of the community, to interpret them to the child-welfare workers.

A school official refers a boy to a child-welfare worker, who will study his home situation.

While the case committee members do not make specific plans for a child, they do think through problems involving the children and give the worker the benefit of different points of view.

Individuals selected for case committees should be tolerant and nonjudgmental and should be willing to listen to both sides of the question.

Through the work of such a committee the child-welfare worker has an opportunity to enlist assistance from others in the community who can help her to find foster homes, secure medical care for children, and assist with school problems and recreational activities. Because of their growing knowledge of case-work services and of detailed information regarding the program the members of the case committee are in a particularly strategic position to interpret further the program of child welfare.

The treasurer of the board heads the finance committee. He issues all checks, keeps an account of expenses, and is responsible for the finances of the board. This committee naturally assumes leadership in securing additional funds from public sources, city and county, for the increased needs of the program.

Where a committee on education and interpretation exists the primary function is to study the entire child-welfare program in order to be able to interpret it to the community. Frequently this committee asks for the opportunity to speak before service clubs, study groups, and other organizations in the community, asking that each of them devote at least one program a year to child welfare. A speakers' bureau, from which speakers are supplied for these programs, has been helpful. It has been found more effective to have laymen interpreting a child-welfare program and discussing its achievements in the community than to have this done by professional workers, who are expected to be enthusiastic about their own programs.

For good public relations

This committee sees to it that information regarding the child-welfare program is given to the press frequently, showing the value of informative news regarding social work and the destructive effects of sob stories.

The value of this was demonstrated by a press report of a case-committee meeting, the agenda of which had been planned around the subject of adoptions. The newspaper article reported the discussion in some detail and gave the names of the committee members attending. The last sentence of the article stated that the committee had taken under consideration the current adoption problems of the child-welfare unit.

As a result of this article a local attorney gained a better understanding of the factors involved in adoption placements and of the community's interest in having a good adoption program. He telephoned the child-welfare unit the day the article appeared, to say he was withdrawing from a case in which he was representing the adoption petitioners, who were contesting the unit's custody of the child.

Committee gives practical help

The service committee, as its name implies, serves in the material sense, making arrangements providing for clothing, shoes, hospitalization, nursing service, and so forth. The members may make available supplementary diets, including grade-A milk for children needing it. In some communities a very active motor corps has been or-

(Continued on page 206)

The American Scene as a Background for a 1950 Conference on Children

KATHARINE F. LENROOT, *Chief, Children's Bureau*

TOWARD THE CLOSE of the last century some pioneers in the field of human welfare hoped that the twentieth century would be the "Century of the Child." Instead, the first half of the century has been marked by wars, depressions, and world-wide terror and destruction. Civilization is now at the crossroads. As we approach the midpoint of the century, we find much of the world struggling, in the shadow of division and aggression, to emerge from the devastation of war, and we know that the character of our own participation in world events will be a decisive factor in determining what the next 50 years will be like.

Of one thing we can be sure—we must press forward in the task which has challenged the best efforts of so many in the past five decades—the task of assuring to all children their full opportunity to develop their capacities and powers for personal fulfilment and social usefulness. We must begin in the homes and communities where the children of our own country live, but we must play an enlightened and generous part in a world-wide movement in behalf of childhood.

Some of the major developments in relation to children and youth that face us now are these:

Birth rates and population increase

About 3,900,000 live births occurred in 1947, the largest number ever reported in this country. This represents an increase of over 50 percent as compared with 1940 figures. The number of children under the age of 5 years in 1947 was 36 percent higher than in 1940, but in the Western States the increase in this age group was 76 percent.

As a result of the increase in birth rates, more than 5,000,000 children will probably be added to the elementary-school population within the next decade. It is obvious that there will be tremendous pressures for expansion on schools, and on health and social agencies. This will be particularly acute in the West, where the greatest increase in child population under the age of 5 years has occurred.

Mobility of population

This decade has seen great shifts in population. Between 1940 and 1947, about one-fifth of the families had moved from their county of residence and were living in another county, and often in another State. The movement was primarily from agricultural, rural areas, to industrial urban areas, and from the North and South to the West. Some 5,000,000 people living on farms migrated to cities during the war years, and a great proportion of these have not returned to farms. As a result of mobility and of the foreign service which so many of our young people have seen, millions of people have come to know other parts of the United States and other countries, and have acquired a sense of reality about the outside world. On the other hand, migration has subjected many families to special strains.

Economic conditions

There were some 8,000,000 people unemployed in 1940; in 1947 the number was only a little more than 2,000,000. Progress has not been entirely upward, however. As to real income the peak was reached in 1944. Since then, there has been a decline of nearly 10 percent.

In 1945 the average (median) income of families having four or more children under 18 years of age was about $2,100 as compared with $2,800 for those with one or two children. About one-third of urban families with children under the age of 18 years had annual incomes of less than $2,500, but more than two-fifths of urban families with four or more children under 18 years of age had incomes under this amount.

We have a social-security system, but millions of families are excluded from it. The security it provides is meager indeed. What is the effect of security, or of insecurity, on the development of a child? How do young people in families receiving social-security benefits feel about the system and its effect upon family life?

Housing

In 1947, 2,800,000 families were living doubled up with other families. An additional 500,000 families were living in temporary housing, trailers, rooming houses, and other makeshift accommodations.

It is estimated that at least 1,500,000 new dwelling units should be built annually in the United States. One million units were completed in 1947. At least 15,500,000 units are needed between now and 1960.

Race

At least 13 percent of our children and young people under 20 years of age are subject to discrimination because of race. What does this mean to a child's development? In 1945, the average annual income of nonwhite families was only about half that of white families ($1,538 as compared with $2,718). Nonwhite families are likely to pay more for far less adequate housing. By the tests of maternal and infant mortality, educational opportunity, and all other similar tests, the children of nonwhite families are at a serious disadvantage.

Health

We have made great gains in cutting down on maternal and infant deaths. But hundreds of mothers and thousands

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Excerpted from remarks made at opening session of Conference on State Planning for Children and Youth at Washington, D. C., March 30–April 1, 1948.

of infants still die needlessly. We have increasing awareness of what child health needs are and how to meet them, increased public and private services, new tools in drugs, operations, and preventive measures. We have, however, a long and arduous task ahead before good child-health services are available to all children. Of special importance is more adequate provision for school health services.

Mental health

We are beginning to understand that the foundations of good mental and emotional health, the ability of a person to establish good relationships with other people, are laid in earliest infancy. There is deepened understanding of the importance of the tie between mother and baby. We see the importance of adapting both home and school experiences to the child's individual and developing needs, for leisure on the part of parents and teachers to work together in making possible for the child some unity of experience, attitudes, and aspirations in home and classroom. We see how the home, the church, the school, and the community agencies need to intermesh to afford for the child the milieu and the experiences best adapted to his growth, and how the help of child-guidance experts is often needed.

Home care and the measures needed to supplement or substitute for such care

At the same time, the circumstances of their lives make it increasingly difficult for many parents to play their predominantly important part in the growth of the child's personality. In 1946, almost 2,000,000 women with children under 10 years of age were in the labor force. In the same year, 910,000 women in the labor force were the heads of families with one or more children under 18 years of age.

Nearly 4,000,000 children have lost one or both parents by death; 700,000 are in homes broken by divorce, desertion, or separation; over 100,000 babies are born out of wedlock each year, and over two-fifths of the unmarried mothers are under the age of 20 years.

Education and employment

To provide all children with the educational opportunities they should have requires far greater expenditure and much larger crops of well-trained teachers. Can we afford the sums required to finance an adequate level of education throughout the country? Can we afford not to spend them?

How can education be more adequately related to vocational guidance and placement?

What measures are necessary to assure a sufficient supply of technically trained people for technical pursuits, and of professionally prepared people for the various professional services modern needs require?

On the basis of present estimates, we need at least 5,000 more pediatricians, 50,000 more public-health nurses, 100,000 more teachers, 15,000 more child-welfare workers, 10,000 more psychiatrists for children's and family services. How are we to get these additional workers with special preparation?

These are some of the factors in our national life which we shall have to consider, as we face forward toward the task of preparing children and young people for the conditions they will meet and the responsibilities they will have to assume. We cannot know what the future will hold, but we should be able to assume in some degree at least what characteristics and qualities of body, mind, and spirit will be essential if youth are to develop so as to play their part in the task of building a world order based on peace, justice, human freedom, and the exercise of social responsibility. May not our first task in preparing for a Midcentury White House Conference be to develop clearer understanding of these qualities, and to test all our provisions for children by the criterion of what they contribute toward children's development?

In 1947, about 3,900,000 babies were born, the largest number ever reported in this country.

FOR CHILDREN WHO NEED FOSTER CARE

MARGARET A. EMERY

Field Consultant on Foster Care, Social Service Division, Children's Bureau

HOW can we provide good foster care for all children who need it? What are some of the recent developments that may affect our planning of foster-care services in a given State or community? How have Federal funds for child-welfare services aided in improving foster-care services?

First, we must look at foster care in its proper setting as part of a broader program of social services to children. We must think of services to the child in his own home, which may make foster care unnecessary. But if foster care becomes necessary, we must think of the services that should be available to protect all children in such care. Then we shall be ready to consider special types of foster care and the problems concerning such care in a given community.

In looking at foster-care services in this way we must consider State services and local services, and the problem of getting personnel for both types of service.

What are State services?

As State services, we think of the protections that the law prescribes for all children of the State. We think of the services of the State public welfare department for assuring adequate standards of child care. We think of that department's leadership and guidance in development of child-welfare programs. We think of the help the department gives local agencies, public and private, to improve their programs. We think of the funds provided to local public welfare departments for staff and for children's maintenance. We think of the safeguards for children in foster care, children born out of wedlock, and others who need special protection. In brief, we think of the laws, the staff, the facilities, and the funds that express what the State wants for its children.

What are local services?

Now let us look at local services—those given in the community where the child lives. They are provided by both public and private agencies. They offer a wide variety of facilities—foster-family homes, institutions, and day-care centers. They include case-work services to individual children; they include also services to children in groups. They include the help that the social worker or the executive gives toward improving the community's program or the community's understanding of children, individually and collectively. They are all that the community does to make it possible for each child to receive the social services he needs, when he needs them.

Stating the problem

The problem facing us today is: How can we obtain the necessary State and local services for children who need care away from their own homes? How can we obtain personnel to give these services?

State services expanded

What are some of the trends in State services that may help us in solving this problem?

The first and most important trend is toward acceptance of governmental responsibility for welfare services, with broad services for children as an integral part of them. Nothing has contributed more to this trend than the Social Security Act, passed in 1935. Under this act the States have been able to move forward on a broad front in their child-welfare programs.

Before 1935 many States had no State-wide public services primarily for children, except perhaps State institutions. Now every State has recognized in law its responsibility for the protection of children. Every State has a State public welfare agency, or a separate division or bureau of welfare, including child welfare, in a State department.

Although Federal funds for child welfare are very limited, they have played an important part in strengthening State services for children. Increasingly, State public welfare departments are providing general child-welfare consultants to give regular help to every county in the State. In addition, during the current fiscal year a number of States have budgeted Federal child-welfare funds for personnel to develop special services for foster care: In 15 of these States, to work with children's institutions, especially State institutions; in 12, to give special service in adoption programs; in 18, to improve such services as foster-family care, day care, or licensing of child-placing and child-caring agencies.

The second important trend is away from merely providing protection for isolated groups of children and toward providing it for all children needing care away from their own homes. We see this trend in several aspects:

Within the last 5 years about half the States have passed laws concerning licensing of child-care facilities. The older laws provided for licensing certain types of foster homes, such as those caring for more than three children or those caring for children under 2. The newer laws, recognizing that the State has responsibility for protecting all children in foster care, require a license for operating any type of foster home, without regard to the number of children cared for or their age.

Likewise, more children in group care are receiving protection. The pressures of the war stimulated provisions for licensing day-care centers. Recent developments in legislation concerning hospitals have affected the licensing program for child-care facilities. States are clarifying the division of responsibility for licensing between

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Condensed from remarks made before the Conference Group on Child Care, Welfare Council of New York City, April 1, 1948.

health and welfare departments, according to the primary purpose of the service provided. In this way they are moving toward making sure that all child-caring facilities are covered by the licensing law.

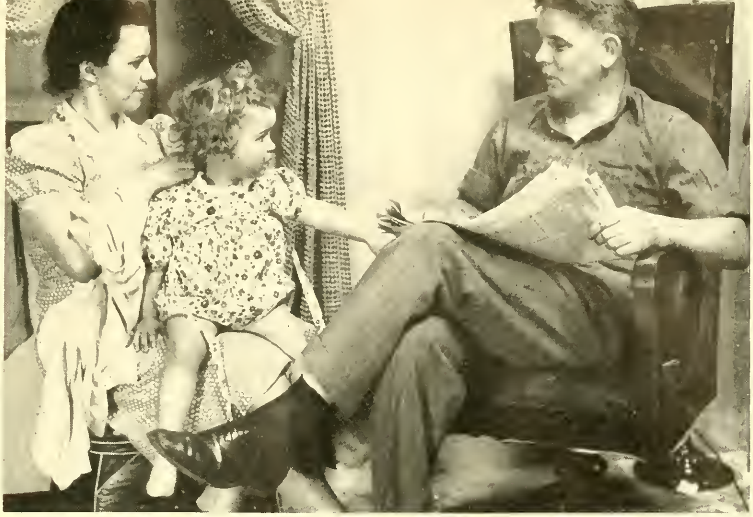
The responsibility of the State in relation to adoption has recently received special attention in practically every State. In 1947 the legislatures of two States enacted new adoption laws and at least 22 amended the old laws.

The Children's Bureau some time ago prepared a preliminary draft of a statement of essentials of adoption law and procedures. The Bureau recently invited a group of staff members from both public and private agencies to give us their advice regarding proposed changes in this statement. These persons came from 11 States that have wide variations in their adoption and public welfare laws. Both the legal and the social-work profession participated.

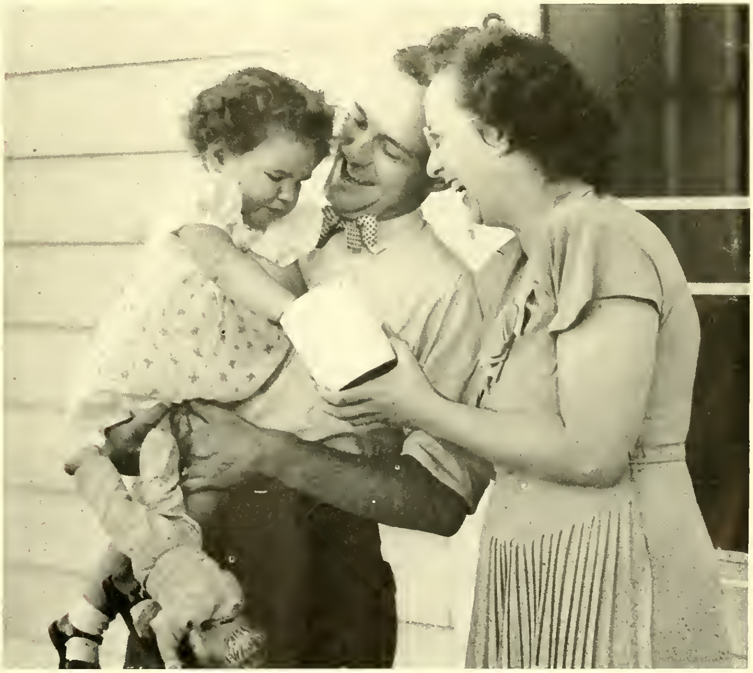
The group was unanimous in believing that the State public welfare department has the ultimate responsibility in adoption. They pointed out that the court makes a legal determination as to what is best for the child. The State public welfare department, as administrative agency of the State, then becomes responsible for seeing that services are rendered. It can delegate some activities, but it still has over-all responsibility for this duty.

One of the most significant outgrowths of the interest in adoptions is recognition of the importance of basic social services. Obviously the most effective time to safeguard the child is when he is about to be placed, rather than afterward. Therefore State public welfare departments are stressing development of social services not only for children being adopted but for all children for whom care away from their own homes is considered.

This movement toward safeguarding all children placed away from their own homes is part of a broader movement, recently described by Dr. Donald Howard as "the gradual development of social work from a salvage operation picking up broken bits of humanity to a far more constructive role." This role is to make available to all children and all families the social services that have heretofore been available primarily to disadvantaged groups.



Home is the best place for most children. For children needing foster care, a variety of services should be available in the community to assure protection of their health and welfare.



The third helpful trend is toward enrichment of foster-care services through a variety of social services and through the contributions of other professions. Especially since the end of the war, many States have organized groups to consider the State standards for foster care and bring them abreast of modern concepts concerning children. Case workers and group workers participate, along with psychiatrists and other doctors, nurses, and educators. Early standards for foster care generally took account mainly of the physical aspects of care. Now there is an effort to develop standards that consider the emotional and social needs of the child also.

Licensing programs are undergoing

transformation and are taking on a more positive, dynamic character. No longer do we think of licensing merely in connection with periodic inspection. It is becoming a continuing educational process. With the expansion of public-health services, it is now possible for State public welfare departments to bring to foster-care agencies, through the licensing program, medical, nursing, nutrition, psychiatric, and other consultation not previously available.

Changing patterns in local services

Going now to local services, what developments here are significant in getting good foster care for all children who need it?

Perhaps more than any one thing, expansion in local public welfare services for children has changed the picture of local services to children, although this expansion has not been so rapid nor so extensive as that in the public-assistance program, largely because the funds for child-welfare services are limited.

Before the Social Security Act was enacted, in 1935, only one-fourth of the States had made provision for local public services for children through county organization under State leadership. Now every State has a plan that includes, in at least some localities, public child-welfare services by local child-welfare workers.

Expansion of local public services in adoption is noteworthy. The importance of agency participation in adoptive placement is better recognized. Many States now require a social investigation before a child is adopted. All this has created a much greater demand for agency services. In some States where adoption services were previously provided only by private agencies, these are no longer able to meet the requests for service, and the State has been making adoption services part of the public welfare program. Other States have been expanding such services.

Another development in local services is a diversification of foster-care facilities. The possibilities of both group and individual foster care have only begun to be considered. Many agencies are experimenting in developing special types of care through foster homes. Others are critically evaluating institutional programs to define better the needs that can best be met through group care and to look toward more specialized institutional services.

Day care has been described as "an orphan of postwar reconversion." Day-care programs had a healthy spurt during the war. Then suddenly they were left without support—too often they became nobody's responsibility. Why is this? Is it because we have not yet reached agreement on the role of the public schools and the social-welfare agencies in providing day care? Can we use our wartime experience to show the variety of day-care facilities needed and to decide where responsibility should rest for providing them?

This year, for the first time, Federal child-welfare funds are being used to provide temporary foster-family care for certain children for whom the local community has no resources. Twelve States have budgeted Federal funds for projects for children in need of emergency, detention, or interim care and for unmarried mothers or their babies or both. Through these projects there is an opportunity for the worker to explore the use of special tools for better care of children.

Because we are still examining and expanding the uses that can be made of foster care, we are not yet able to define adequately what facilities should be available as part of a well-rounded program of foster care. This adds to our problem of how to give such care to all children who need it.

One important development in local services is the change in relationships between public and private agencies. Extension of public services has brought to the forefront the question of how responsibility between public and private agencies should be divided. Services of private agencies are largely concentrated in urban areas. It is here that we see the major changes taking place.

Redefinition and realinement of functions have been high-lighted in recent studies of child-care programs, such as those in Chicago, Dallas, New Orleans, St. Louis, Washington, and Boston. Because of the variation in the nature of the studies, as well as in community programs of service, it is not possible to draw any general conclusions from them as to relations between public and private agencies. However, two things are clear: Public services for foster care are expanding in most cities and there are many unmet needs in all cities. Evidences of these are repeated in annual reports of agencies and of councils of social agencies.

A few illustrations may show the nature of the expansion of public services:

When the Children's Division of the Chicago Welfare Administration was established in 1934, its services were restricted to children whose parents were receiving relief under the Pauper Law. This policy was liberalized in 1942, and again in 1944, to include a much larger number of children. By 1943, it had become the largest child-placing agency in the city.

In Washington, D. C., in 1942, Federal legislation was passed to enable the public welfare department to provide protective services to children and foster care for children under 18 not in need of commitment.

In 1946 the city of New Orleans discontinued lump-sum appropriations to private institutions and began payment on a per capita, per diem basis. At the same time, the city department of public welfare was recognized as the agency to administer public funds for such services.

What about personnel?

Personnel is, of course, the manpower that provides the services that children need. The serious shortage of people trained in social work is an outstanding difficulty in the way of providing both State and local services.

Gaps in service

The unmet needs are legion. Some stand out: Need for services to children in their own homes; need for foster-care services and facilities of all kinds for mentally retarded children, children with emotional and behavior problems, Negro and other children in minority groups, and chronically ill or convalescent children; need for services and facilities for unmarried mothers; need for facilities for emergency and detention care; and need for specialized institutional facilities.

Another problem forces its way into practically every local program of child care. That is the problem of financing. Public agencies for the most part are not providing funds to cover the cost of care. Low board rates prevail for foster-home care. When the facilities of private agencies are used, the private agency often must draw on its voluntary contributions to pay for the care of children referred to it by the public agency. I do not believe this is sound from the point of view of either the public or private agency.

Is it too much to hope that we can look forward to a development in the child-welfare program similar to that in the family-welfare program?

Many of the best private family-welfare agencies are saying that they no longer are willing to accept cases primarily to supplement inadequate public-assistance funds. They believe that public agencies should provide adequately for the persons for whose care they are responsible and that the private family agency's services should have an identity of their own in the community. They want to be free to move into new areas of service—to reach people not now being reached by either public or private agencies. If they can do this, they can describe their program in terms the community can understand.

Only as the community understands the identity of these services can it associate them with the need for funds. Are not these concepts as applicable in child welfare as in family welfare?

One fact stands out. We are not yet, in any community I know of, meeting the existing needs for foster care. With the combined resources of public and private agencies, we are still far from achieving our goal of providing for every child in need of foster care the kind of care he needs.

How, then, can we make the best use of public and private agencies? What should be the pattern of relationships between public and private agencies providing foster care?

Could we use the following principles as our guide in planning the changes in our relationships?

A possible guide

1. The local public welfare department should assume responsibility for providing a broad program of services to children. This is a part of government's responsibility for providing basic security for its people.

These services should go beyond those for economic security and should include services to people who lack security because of personal, family, or community conditions. They should include case-work services to children in their own homes as well as in foster care. They should be available to every child in need of such service, without regard to legal residence, economic status, race, creed, or any consideration other than the child's need for such service.

The local public welfare department should have the necessary staff, funds, and facilities to provide such services directly, on a continuing basis.

2. The private agency should have responsibility for carefully selected functions that assure the community of continued progress in the development of specialized services beyond those recognized as public responsibility; of new types of service; and of research and experimentation to bring new skills and new thinking to the community program of child care.

3. The public welfare department should utilize available private-agency resources, on the following basis:

a. The need of the individual child for the type of care or service provided by the private agency should be the first consideration in selecting the private agency to give it.

b. When the public welfare department accepts responsibility it should be prepared to meet the full cost of the child's care. This should be on a per capita, per diem basis.

c. The private agency should meet the standards of care established by the State public welfare agency.

d. The private agency's acceptance of a child for whose care the public agency is responsible should be on individual request and by mutual agreement between the public and private agency. Children should not be accepted as public responsibility merely as a step in the intake process of a private agency to assure payment of funds for the child's care.

e. The public welfare department should have continuing responsibility for planning for the care of the child and should participate in deciding how long the child needs the type of care provided by the private agency.

A great factor in obtaining good foster care for all children who need it is personnel to provide the services. The problems due to lack of staff are well known, and in planning foster-care services we need to continue to give major attention to these problems. The experience of the past decade has taught us, or perhaps reaffirmed a conviction, that we must rely on a planned agency training program to take up the slack caused by the shortage of trained social workers. More and more States are using a carefully planned educational-leave program as one method of assuring gradual but continual improvement in the professional competence of staff in the public child-welfare program.

How achieve adequate services?

Finally, I want to speak briefly about *how* we achieve adequate foster-care services in a given State or community. There is no easy rule for this. The steps will necessarily differ from community to community, depending on the stage of development of public and private agency programs and on the community's understanding of children's needs. But there are certain ways in which each of us may help.

1. We must have a deep and abiding conviction of the importance of providing for every child the care he needs to assure optimum growth and development. In a democracy with a concern for every human being, we can be satisfied with no less than this.

2. We must continue to have participation of lay groups and individuals. The interest of people in children is like a fresh-water spring. It runs on and on, giving all the while something vital to our growth. The responsibility is ours to see that we use this interest in a way that adds strength and vitality to our services to children. This calls for dynamic community planning to bring the best that we can offer, as lay or professional individuals, through public and private agencies, to meet the needs of children.

3. We must have the courage to change. Giving up old ways and taking on new ones is never easy. But it is part of our job as social workers. Social work is a young profession. Foster care programs are not fully developed. We must broaden services, develop new ways of helping children, discard old ones. To progress, we must change. This is not only an opportunity but an obligation for each and every one of us!

Reprints available in about 5 weeks.

National Health Assembly looks at health of mothers and children

ON MAY 1, 1948, the day set apart by the President of the United States as Child Health Day, the National Health Assembly came together at Washington to see what we of this Nation now have in the way of health, to determine what we lack, and to set 10-year goals for meeting the deficits and raising the level of the national health.

The assembly, which had been called together by Oscar R. Ewing, Federal Security Administrator, as the result of a suggestion made by President Truman, met for 4 days. And throughout this period the health of mothers and children was an important part of the discussions in nearly all the 14 sections into which the more than 800 persons attending were divided, such as the sections on nutrition, on dental health, on hospital facilities, on rural health, and on mental hygiene.

One section, however, was entirely devoted to the subject, "A National Program for Maternal and Child Health"; and it is this section whose work is reported here.

Where are we now in maternal and child health? This is the question that had to be answered first. And the maternal and child-health section's report describes many gains.

Death rates lower

More mothers, the report says, are surviving childbearing than ever before in our history, and more babies live beyond the first year. From 1933 to 1945, the infant mortality rate dropped by more than one-third; the maternal mortality rate by nearly two-thirds. But, the statement goes on, we must not measure success only by falling death rates. For what kind of life are these mothers and babies being saved? We have yet no yardstick to measure success in terms of positive health for the mother, the child, or the family.

Still, the gain in lives saved is important, and the section reports that many of these gains are due to the steadily improving quality of obstetric care given by physicians—both obstetricians and general practitioners. The sulfa drugs, penicillin, streptomycin, and use of blood transfusions and plasma have helped; likewise X-ray examination of the pelvis during pregnancy. Better nutrition, knowledge about the Rh factor in the blood, and new methods of anesthesia have also helped toward saving mothers' lives. Growing concern for the emotional security of mother and baby, and the whole family, have led to reemphasis of breast feeding and to experiments in keeping mother and baby together in the hospital.

The gains in saving mothers' lives have not been alike in the States nor in white and nonwhite groups. In Wyoming the maternal death rate in 1945 was 9; in Mississippi it was 38. Between 1933 and 1945, for white mothers throughout the country the maternal death rate fell from 56 deaths per 10,000 live births to 17. For nonwhite mothers, the rate fell from 97 to 45.

Recognize need for early care

A significant change in recent years has been the growing awareness among expectant parents of the need for good care early in pregnancy. A large proportion now seek care by the third month.

In spite of gains in saving babies' lives, the section on maternal and child health warns, we must remember that each year more than 100,000 babies in the United States die in their first year of life. Two-thirds of these die in the first month, and we have made little progress in cutting down on the deaths of these younger infants.

Prematurity is the greatest single cause of death among infants. About 12 out of every 1,000 babies born alive die as the result of premature birth. With good care this rate can be greatly reduced.

From Pearl Harbor to VJ-day, the statement reminds us, 281,000 Americans were killed in action. In the same period, 430,000 babies died in the first year of life. Many of these deaths were preventable.

The mortality rate for children of preschool age (1 to 4 years) has dropped more than that for infants, or for the 5- to 14-year group, or for the group from 15 to 18 years, according to the report. The rate for preschool children was halved during the period 1933 to 1945; for the 5- to 14-year group the cut was nearly as large.

Accidents are now the chief killers of children after the age of 1 year, says the report.

The report estimates that 35,000 children in the United States are handicapped by diabetes; 175,000 by tuberculosis; 200,000 by epilepsy; 500,000 by rheumatic fever and rheumatic heart disease; and 500,000 by orthopedic and plastic defects. Another million children have hearing defects; 4,000,000 have visual defects; and 20,000,000, dental defects. The figures on mental disease are not known, but 18 out of every 100 "4F's" in selective service were rejected because of mental and personality disorders; and we know that most of the problems of mental health start in childhood.

The best that the section's report can say of medical services throughout the United States is that they are spotty. This is true of general medical care; well-child conferences; public-health nursing; medical-social services; dental, mental-hygiene, and school-health services; and convalescent care. The report quotes a study of eight States, by the American Academy of Pediatrics, to show that children in some States receive only half as much care as children in other States.

Almost universally the services for school-age children are among the weakest links in the chain of maternal and child-health services supplied by States and communities. Many States undertake to make physical examinations or inspections of school children through either their health or their education services, but even this elementary health protection is not mandatory everywhere. The quality of examination varies greatly. In many schools, inspection is made by the teacher, the principal, or the school nurse. Some 4,000,000 children live in counties where there is no kind of examination by doctors in public schools. In a great majority of our school health programs, no remedial action is taken, even when handicapping conditions are found. Year after year, the same condition is rediscovered.

The number of employed children is considerably higher than before the war. Only one-third of the States have established a basic minimum age of 16 years for employment outside school hours or in manufacturing. Employment of children in commercialized agriculture is for the most part unregulated. The wartime relaxation of child-labor standards and the lack of adequate legislative protection in the employment of chidren endangers their opportunity for physical and mental health and development.

For the coming decade

After taking stock of present conditions in maternal and child health, the section looked toward feasible goals for improving these conditions in the next 10 years. For this purpose it divided itself into six subcommittees. One of these reported on research in child life; another concentrated on standards for hospital care of mothers, newborn babies, and older children; and a third, on parent education. Another subcommittee studied training of personnel to care for mothers and children. Health of the school-age child was the subject worked on by the fifth subcommittee; and the sixth reported on the care of handicapped children and the prevention of accidents.

Expansion in research up to now has been chiefly in the physical sciences, reported the subcommittee on research in child life. No less important has been the gradual acquisition of knowledge of the growth and development of children. But no all-out concerted effort has been made to find answers to problems concerning children's health and welfare.

Just as child health is no longer considered entirely the result of medical care, but the product of endeavor by many professional and nonprofessional disciplines, went on the subcommittee, so research in child health has been broadened to include many fields which may better be grouped under the term "child life." The interaction of a child and his environment is so complex that research into almost any of his problems must have a multidisciplined approach. What appears on the surface to be a simple physical problem, such as inability or failure of mothers to breast-feed infants, needs a combined attack from the fields of medicine, psychology, anthropology, economics, and others.

The subcommittee pointed to many conditions in which large sums and great effort are spent in caring for the end results, while research into the basic causes of the problem is neglected.

An example of the types of research urgently needed, which are beyond the capacity of any individual or single research group, is the changing pattern of family life. Studies of family life are needed which take into consideration the fields of health, social services, mental hygiene, and education, and also the cultural patterns of child rearing. Consideration should also be given to the economic basis of family support of children.

Early infancy is full of problems, went on the subcommittee, for which our answers so far are largely in the form of theory and speculation. Self-regulation schedules for babies' feeding; "rooming-in" of mother and baby, and how it may be accomplished in our modern hospital system; the infant's need for early attachment to one person and how that affects our adoption procedures; all need thorough, impartial investigation. Already wide application is being made of theories of child care for which adequate supporting data are not available.

Standards respond to demand

Standards of hospital care for mothers and children will be raised when the people know the meaning and the value of good care, said the report of the subcommittee on standards of maternity, newborn, and pediatric hospital care. Recommending that every mother and child receive the best hospital care on the basis of medical need only, and that this care insure the emotional security as well as the personal dignity of each patient and family, the subcommittee urged that educational guidance by highly qualified hospital consultants accompany the inspection that is necessary for enforcement of licensing laws.

If the needs of the whole personality of each mother and child are to be met, continued the subcommittee, the community facilities for prevention and treatment of disease should be joined with those for development of mental and physical health, with the hospital as the center.

High-school girls can learn much that they need to know as future mothers by practicing with a doll. But they need also opportunities to observe real babies and see how they grow.

Continuity of care for mothers and children was urged by the subcommittee, preferably through hospitals having their own out-patient services.

An additional plan for using hospital facilities efficiently called for institutional or foster-home care for convalescent children, with adequate services to meet their psychological, nutritional, social, medical, and nursing needs.

Development of a series of interlocking regional plans to make services of hospital-health centers available to all mothers and children, no matter where they live, was urged by the subcommittee.

Suggesting development of standards of hospital care for mothers, newborn infants, and other children, the subcommittee agreed that the psychological, social, and physical needs of the individual should be taken into account in these standards.

Every citizen, said the subcommittee, should be made aware of the health needs of himself, his family, and his community, and should be taught to select good medical, nursing, and hospital care.

We believe, said the subcommittee on parent education, that all expectant parents should have available to them the fullest knowledge of the life processes that are involved in childbearing, including the importance of their own feeling and attitudes. They must know the facts about how a baby is conceived, grows, and is born, and the relation of this information to the selection of a doctor, a nurse, and a hospital, and the creation of a happy home into which a child is to be born and in which he will grow and thrive and become a well-balanced individual.

Teach parent how child develops

Parent education, the subcommittee said, is an attempt to communicate to parents the new knowledge and understanding of child growth and the recently developed insights into personality development.

It is much more than the teaching of subject matter, the subcommittee continued, since it involves radical changes in the ideas and beliefs and expectations of parents and their replacement by newer concepts.

Such education should be available not only to couples who already have children, but to those expecting a child, and to growing boys and girls, who are the future parents. It should begin in the home and the school, and continue in the doctor's office, in the clinic waiting room, in the nurse's home visits, in the clergyman's interviews, in classes for expectant parents, in counseling and family interviews, in the press, over the radio, and by other means of mass education.

Emphasis on prevention and education will reduce the present need for corrective procedures.

The content of parent education, said the subcommittee, should include knowledge of the principles of physical care that contribute to sound bodily growth, as well as the basic factors that enter into the intellectual, emotional, and social development of the child. As far as possible, therefore, all professional groups involved in counseling with parents should have at their command a unified body of information about physical and mental growth and their interrelationships.

More training, graduate and undergraduate, for physicians who care for mothers and children was the first concern of the subcommittee on training of personnel. This is important, said the subcommittee, not only for general practitioners, but for pediatricians, obstetricians, and other specialists in maternal and child care.

The quality of nursing service in all phases of maternity and pediatric care depends upon the improvement of basic nursing education, the subcommittee said. Emphasis in all basic sources should be on the emotional, social, and health aspects of care. It is desirable therefore that young women who are qualified for professional nursing be recruited and directed to schools that meet the standards of institutions of higher learning.

In-service training urged

Public-health nurses already in the field should be provided with opportunities for training in service related to the care of mothers and children, according to the subcommittee.

The subcommittee on personnel training recognized the need of more adequate funds in support of medical and nursing education, especially in branches relating to obstetrics and pediatrics. Lacking resources from medical-school budgets, or endowment funds of universities, serious consideration must be given, the subcommittee said, to the proposal to seek new Federal funds, in addition to increasing Federal funds already being used in special fields of education, in aid of general medical education, or of specific disciplines in medical curricula which affect maternal and child health.

Medical and psychiatric social service should be available as an integral form of medical care to every mother and child who needs this service, in the opinion of the committee. During the next 10 years, the subcommittee stated, greater emphasis should be placed on sharing the findings and interpretation of medical-social and psychiatric social workers with other professional and community groups. And in addition such workers should assume more responsibility for developing resources to meet social-welfare needs in the community.

Nutritionists trained in social service

The subcommittee stressed the importance of nutrition in maternal and child-health work, saying that during the next 10 years an adequate number of qualified nutritionists should be provided, to work with public-health, education, and welfare agencies. These nutritionists should be trained in social sciences, with special emphasis on education and psychology.

The subcommittee on health of the school-age child set forth goals in this field that require increased funds, personnel, and facilities. Stating that legislation on Federal and State levels is needed in order to reach the goals, the subcommittee said that much can be accomplished by cooperative planning and better use of the present facilities and personnel, and that an informed public opinion is essential to progress toward better health for children of school age.

Taking up the mental health of the school child, the subcommittee called attention to the fact that a child's inability to develop satisfying relationships with his teachers and classmates may cause him worry and insecurity. It was recommended that the curriculum be developed with the emotional as well as the intellectual needs of the child in view, and that the great individual differences among children be more definitely recognized.

The subcommittee recognized that the nutrition program for the school-age child, including the school lunch, is a significant part of the total health and education plan of the school, and listed ways of achieving the objectives of the program.

The subcommittee on care of handicapped children, including prevention of accidents, did not try to set up a definition of a handicapped child, but it did recommend that the States broaden their basic definitions, which are now often limited to children with conditions requiring orthopedic or plastic surgery. Such definitions should be broadened to include children with other physical handicaps, such as heart disease; neurological conditions, including cerebral palsy and epilepsy; speech, hearing, and visual defects; and other conditions that can be considered as handicaps to the individual afflicted or to his family because of definite social, psychological, or economic implications. Children with severe mental handicaps should have consideration too, though educational and mental-health resources will need to assume a greater proportion of responsibility for their care than for children with physical handicaps alone.

In order to find out how many handicapped children and adults we have in this country and in what way they are handicapped physically, mentally, and socially, the subcommittee recommended that a census based on standardized definitions be taken. This would help to determine the size and location of facilities and the number of various types of personnel that would need to be trained to fulfill the needs of the handicapped.

Complete medical rehabilitation, the subcommittee said, requires that every individual who suffers a physical, mental, or social handicap should have available without discrimination all the services that will help develop his abilities for as full and useful a life as is consistent with his handicap.

To prevent accidents

As was mentioned in another part of this report, accidents kill more children over the age of 1 year than any disease. The subcommittee recommended that official responsibility for prevention of accidents be vested in health departments and that in each State and metropolitan health department there be appointed an official whose function it would be to develop and coordinate community activities in this field. Departments of preventive medicine and health education in the universities and in the health departments should carry major responsibility in this program.

Research into the accident problem needs to be carried on, the subcommittee added, so that the Nation will be familiar with the real magnitude of this danger, will know more about the causes of accidents and about methods of preventing the large proportion of them that we know are preventable.

What the section recommends

The maternal and child-health section of the National Health Assembly recommends that:

1. A vigorous program of research in matters related to child life should be established, and supported where necessary by increased Federal grants. Such research should include a combined attack from fields of medicine, psychology, anthropology, sociology, education, economics, and other related fields, with special emphasis on accidents, rheumatic fever, premature birth, child behavior, ways of modifying attitudes of parents, and the effects on children of the changing patterns of family life.
2. A central clearinghouse should be established in which research problems and projects may be recorded, in order to maintain a free exchange of information for all workers, to avoid duplication of effort, and to suggest research needed to fill gaps in our knowledge.
3. Federal grants should be increased and extended to provide training of professional personnel responsible for medical care and health supervision of mothers and children.
4. The Children's Bureau, with other appropriate Federal agencies and professional organizations, should develop standards of care for maternal and child health. The psychological, social, and physical needs of the individual should be taken into account. Standards should be set up whenever possible in a form that makes them useful to the local community that wishes to use them.
5. There should be only one standard of hospital care for all mothers and children—that which puts into practice the newest and best medical and nursing knowledge and techniques for each patient and uses every modern facility and service, on the basis of medical need, rather than on the basis of ability to pay or other barriers. This care must insure the emotional security as well as the personal dignity of each patient and family.

The development or revision of hospital-licensing systems is recommended. Systems which provide merely inspections for sanitary and fire hazards and emphasize minimum standards are inadequate. A revised licensing system, placing full authority in the hands of the health department, should aim at achieving high standards, not minimum requirements. The enforcement of licensing laws is more effective in raising the level of service in hospitals when, rather than mere inspection, educational guidance is provided by highly qualified hospital consultants.

6. A vigorous program for education of parents in child rearing should be undertaken. Although members of many professions and a variety of community agencies are concerned with this program the prime responsibility must rest with health and education authorities, who should develop and maintain extended programs for parent education.

7. In the education of physicians, nurses, social workers, teachers, and other professional personnel who work with children more information concerning growth, development, and behavior of normal children should be included.

8. Local communities should take initiative in developing experimental projects designed to solve their own local problems, and a wide variety of methods of attack should be encouraged.

9. Since accidents are the chief cause of death of children above the age of 1, accident prevention should be considered a major responsibility of State and local health departments, and persons qualified in this field should be included on their staffs.

10. To have an adequate and sound national plan for the treatment, care, and rehabilitation of children with physical and mental handicaps, a census of such children should be taken by the Federal Government at regular intervals, beginning with the census in 1950.

11. To achieve complete health for every child, voluntary and official agencies should develop closer working relations and seek every opportunity for joint effort.

12. Because of conflicting and restrictive laws and regulations children are often prevented from securing available health services. A critical study should be made which should result in the removal of such legal limitations and promote better care.

13. The Federal Security Administrator should call a national conference on school health, with adequate representation of the constituent units of the Federal Government and of medical, public-health, dental, nursing, educational, and other professional and related voluntary and lay groups to determine goals and recommend procedures for the following purposes:

a. To clarify the contributions which all related groups can make and determine how they can best work together.

b. To help insure more systematic, better coordinated and widespread programs.

c. To promote integration of school efforts with those in the community.

d. To set an example of coordinated action for States and for local communities. The governors of the respective States and appropriate local officials should be encouraged to call similar State, county and city-wide conferences.

14. Services for rehabilitation of physically and mentally handicapped children should be expanded, with increased Federal and State support, and coordinated with programs of voluntary agencies. Current planning for the relation of medical centers to regional and community hospitals should be considered in connection with the development of more and better institutional, out-patient, and convalescent service and after-care of handicapped children.

15. Advances made in past years toward developing and reaching optimum standards and practices of employment and working conditions of women and minors are of vital importance to the health of our Nation's children. Legislation and practices in this regard should be strengthened rather than permitted to go backward, as was threatened in many parts of the country and occurred in some during the stress of the war and postwar periods.

16. The newer knowledge in child rearing, pediatrics, obstetrics, and related fields must be brought to those on the job of caring for mothers and children through extension courses, particularly to the general practitioner.

County Boards

(Continued from page 195)

ganized; this saves the staff many hours of work. Committee service has been a valuable proving ground for board membership.

Realizing that the boards are constantly undergoing changes in membership, that the commissioners courts are not static as to tenure of office, and that it is easy for the unit supervisor in the rush of a heavy case load to take for granted that all members of the board have a clear understanding of the program and their own responsibility to it, the division of child welfare has thought it necessary from time to time to review the program and the functions of the board through the media of discussion groups for board members in the different units of the State.

A consultant from the State staff leads these discussion groups, and the groundwork is laid by the unit supervisor. It is felt that the success of the plan depends on the attitude of the unit supervisor as to the value of the meeting and her interpretation of its value to the board.

The discussion meetings are not mandatory and are held only in counties where the unit supervisor desires such a plan.

In preparing the board for this discussion group the unit supervisor indicates not only that this would be a good time for the members to ask questions regarding policies on any part of the program which they do not understand, but that it is entirely in order for them to express disagreement or any negative reactions that they might have to current practices in the unit or in the department as a whole.

Misunderstanding cleared up

In one county a most helpful discussion group was held in which the board had a very real misunderstanding about the program and had criticized adversely some of the practices. Through the discussion it was learned that there was not complete understanding concerning the functions of the board and those of the staff.

Discussion brought out that the professional staff were the technical workers on the job; that just as a doctor diagnoses and prescribes for a patient, so the worker diagnoses and plans with and for her clients. The board on the other hand serves in an advisory, directory, and limited administrative capacity, which provides a setting the worker finds absolutely necessary for her technical performance. While the board members might be asked for references concerning foster homes or adoptive applicants, it is the child-welfare worker and the other members of the staff, who after studying the child and studying the home, make the decision as to their fitting together.

In large counties where there are a number of community centers, committees have been organized as to locations rather than specialized services. These have performed most effectively in interpreting child-welfare services. In each instance the committee serves as a combined case committee and publicity, education, and service committee, making its report at the monthly board meetings as do all the committees.

Grass-roots data useful

The experience of serving on county child-welfare boards has been a contributing factor in the program of the Texas Committee for Children and Youth. Several members of this State committee are members of local child-welfare boards. They are bringing data to the State committee from the grass roots of the community—data based on experience and thoughtful planning, which have resulted from the activities initiated in the community by the local boards and their committees. These data will be incorporated in the suggestions and reports made by the State committee to the National Commission on Children and Youth, working toward the 1950 White House Conference.

The importance of county child-welfare boards as they operate in Texas can hardly be overestimated. If we subscribe to the theory that no program of social welfare can rise above the understanding and consent of its community we shall have to admit that the work of a county child-welfare board has far-reaching possibilities and should be a contributing factor in sound social legislation for the care and protection of children.

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• IN THE NEWS

States Line Up for White House Conference

Development of State-action programs preparing for the 1950 White House Conference on Children and Youth is gaining momentum. Word comes of organization of several new State councils for children and youth.

The Colorado Youth Council was launched at a meeting May 10, at which over 80 organizations took part, and Sherwood Gates, dean of Colorado College, was elected president. The State federation of women's clubs did much to encourage organization of the council.

The Governor of North Carolina has designated the North Carolina Conference of Social Service as the organization responsible for the State's participation in the White House Conference. As its first step the organization pledged support to the program recommended in January 1947 by the State planning board's committee on services for children and youth. Ellen Winston, commissioner of the State board of public welfare, is president of the North Carolina Conference of Social Service; and Mrs. Tom Grier, of Raleigh, is executive secretary. The State commission on domestic relations statutes and statutes affecting children is drafting the bills called for in the committee report.

Oregon now has a State committee on children and youth, appointed in March by the Governor, to carry the major responsibility of State projects that may develop from the programs of the National Commission on Children and Youth and the 1950 White House Conference. The committee is widely representative of agencies and citizen groups serving children and youth. Mrs. Saidie Orr Dunbar, of Portland, is chairman; Miss Jeanne Jewett, of the State public welfare commission, is secretary. This action gives official recognition to a committee that has been at work for several years.

Wyoming adds to the growing list, with the Governor's appointment, in March, of 30 members of a council on children and youth. Dr. G. M. Willson, superintendent of the State training school at Lander, is chairman. The first meeting was held June 7.

The report of the Conference on State Planning for Children and Youth, held by the Children's Bureau and the National Commission on Children and Youth at Washington, March 30–April 1, 1948, is now ready. It summarizes the speeches and gives the findings and recommendations for organization, fact finding, and action. The report, entitled, "Toward a 1950 Conference on Children and Youth," is intended to aid States and community groups in planning for that conference. Copies may be had from the Children's bureau on request.

For Better Family Life

The National Conference on Family Life met at Washington May 5–8, 1948, with Eric A. Johnston as chairman. More than 900 delegates attended. One of the plenary sessions was addressed by President Truman.

An account of the conference will be published in a future issue of *The Child.*

• CALENDAR

From June 17 (about 3 weeks)—International Labor Conference. San Francisco, Calif.

June 21–24—American Home Economics Association. Thirty-ninth annual meeting. Minneapolis, Minn.

June 21–25—American Medical Association. Annual session. Chicago.

July 5–9—National Education Association. Eighty-fifth annual meeting. Cleveland, Ohio.

July 7–14—First International Congress of Mothers. Buenos Aires, Argentina.

July 12–17—First International Poliomyelitis Conference. New York.

July 18–24—First Inter-American Conference on Rehabilitation of the Crippled and Disabled. Mexico City, Mexico. Sponsored by the International Society for the Welfare of Cripples, in cooperation with the Mexican Government.

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Summer Jobs Dovetail Work and School

Americans believe in education as the right of every child. In a recent public-opinion poll, 87 percent of the people interviewed said they believed that every boy and girl is entitled to a 4-year high-school education, paid for through public funds. To ensure this opportunity we need willingness to provide financial aid to students as a means of keeping in high school young people who otherwise would have to give up their education in order to earn a living.

One way that high-school boys and girls can now earn some money without interfering with their education is to take summer jobs, which offer opportunities to dovetail work and school.

As school doors close this spring, a million and a half youngsters 14 through 17 years of age are surging into the summer labor market, eager for a chance to earn money and to get job experience that will help them in the future. (Two million boys and girls of this age group were already at work in April. And on the basis of what has happened every summer for the past 3 years, there will be a total of at least 3½ million young workers 14 through 17 in July.)

How will they make out, these million and a half young summer-job seekers? And how many of those who have not been graduated will go back to school in the fall? The answers depend in part at least on the people in the communities where these youngsters live; on the school counselor and the local State employment office; on employers; on citizen groups; on labor-department officials; and in part on the young people themselves and their families.

What kinds of jobs will these youngsters find? Will their jobs meet legal requirements under State and Federal child-labor provisions? Will the young workers receive adequate supervision? Will the content of the job be worth while? Will hours and working conditions be suitable and wholesome for children of their ages?

For some kinds of work legislative protection is weak and may be altogether lacking. Industrialized agriculture, with its huge seasonal demand for workers and its willingness to use young children, is an example. Yet even here a strongly motivated community opinion can work wonders in the way of safeguarding children from undesirable or unhealthful working conditions.

In such an effort communities can count on the support of their local State employment offices. The U. S. Employment Service, with its new farm-placement responsibilities, this year is stressing the importance of observing approved minimum-age standards in referring young applicants to jobs.

By watching, this summer, the kinds of jobs boys and girls in our own community are finding, and what their working conditions are, we can get some indication of what further safeguards are needed for working children and how the State law needs strengthening. We should ask also whether these youngsters' summer jobs will help them in growing up—in giving them maturity, responsibility, self-reliance. Teen-age boys and girls are pushing toward independence and toward wider acquaintance with the world and its ways. And the right kind of jobs can make a lot of difference in what young people expect of themselves, and in their knowledge of what employers and fellow-workers expect of them.

If the young vacation workers keep their eyes open, they will get a clearer idea of the values of continued education. And they will decide with confidence and renewed interest to return to school in the fall. Their teachers, alert to the values of summer jobs for students, can use the job experiences to bring realism into the classroom and to increase interest in related studies. If the potentialities of summer jobs as a source of work experience were fully appreciated by the schools, there would be less temptation for young people to surrender their regular school time in favor of paid jobs.

Some forward-looking communities may wish to experiment with planned work projects, through which older high-school students can obtain summer-job experience under desirable conditions and with adequate supervision.

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